Patricia Carrillo Barnes, MS, LPC, LMFT

12915 Jones Maltsberger, Suite 505
210.545.3344

San Antonio, TX 78247
Fax 210.545.3345

Client Information

Date:________ Client Name:________________________________ DOB:________

Your Name:___________________________ Relationship to Client:______________

Client's SSN:_________________ Employer/School _____________________ Grade_____

Home Address:____Zip:__________

Phone No's: (H) ________________ (W)________________ (C)________________

Referred by:________________________________ Permission to contact: yes no

Reason for coming____

PCP/Pedi:___________________________________ Permission to contact: yes no

Emergency Contact:

Name:____ Phone:_______________

Responsible Party: (must be present to sign)

Name:____ Phone:_______________

Signature:____ date:________________

Insurance Information:

Name of Insurance:_______________________ Insured Name:__________________

Employer:___________________________ SSN:_________________ DOB:_______

ID Number:____________________ Group #:____________ Relationship:_________

By signing this form, you are requesting treatment and give permission for exchange of information between your insurance company and Patricia Carrillo Barnes. You also assign insurance benefits to Patricia Carrillo Barnes.

_____________________________________ ____________________________

Signature **Date**

Patricia Carrillo Barnes, MS, LPC, LMFT
Diplomat, American Psychotherapy Association
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Consent for Treatment

Directions: please initial each paragraph as you read through this Consent form. A signature of the client or guardian is required at the end of the form. If both partners or both parents are present, then both signatures are requested.

[initial] **About myself**: I am a Licensed Professional Counselor (#12036) and a Licensed Marriage and Family Therapist (#3768). I have achieved Diplomat status from the American Psychotherapy Association. My Bachelor's degree in Psychology is from U.T. Austin ('85) and my Master's degree from Our Lady of the Lake University ('88).

[initial] **About Psychotherapy**: Your goals for psychotherapy are achieved only by open and honest discussions; however, there are no guarantees. There may be times when you feel discomfort or stress because of our meeting, but there should be no significant risks from therapy. These discomforts may arise because you are changing and achieving some of your goals. Please be sure to let me know of any stress that you are experiencing.

[initial] **Session and Fee Information**: Sessions usually last about 45 minutes. The initial session cost is $125, with subsequent sessions costing $100. I try to end on time, but may run late depending on the circumstances. All fees are expected at the time of our session. I submit any insurance claims as a way of reimbursing you, but *remember that for any number of reasons beyond my control your insurance may not pay for your session. You are ultimately responsible for payment for each meeting.*
Your appointment time is reserved for you. If you do not cancel at least 24 hours prior to your appointment time, you will be charged a "No-Show" fee of $50, which your insurance does not reimburse and you must pay. A $25 fee will be charged for any checks returned for insufficient funds.

[initial] **Confidentiality**: I adhere to all ethical standards of my licensing Boards. Confidentiality of your records and information is your right. You must sign a form for Consent to Release Information prior to allowing me to recognize you as a client or to exchange any information with anyone. There are four (4) exceptions to these rules:

1. By state and local laws, I must report all cases of physical and sexual abuse and neglect of minors or the elderly to the appropriate authorities.
2. By state and local laws, I must report all cases where there exists a danger to self or others.
3. In legal cases, your records may be subpoenaed by any party.
4. In the event of medical emergency where medical personnel will need to be contacted.

Please keep in mind, that insurance companies request information, mostly limited to your diagnosis and treatment. I have no control over how they will use the information. But be aware that I will make every effort to protect your confidentiality and privacy to the best of my ability.

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[initial] **Coordination of Treatment**: Most insurance companies request that I contact your Primary Care Physician/Manager (PCP or PCM), and inform them that you are in treatment with me, especially if you are taking medication of any type or have a medical condition. If you chose to give me consent to release information to your PCP/PCM, you will need to fill in the attached form with their name and telephone number. You can choose to decline to give me permission to contact your PCP/PCM on the same form. There should be no negative consequence to decline the consent for information to be exchanged between me and your physician if you so choose.

[initial] **Court Testimony**: As a Marriage and Family Therapist, it is unethical for me to do any forensic evaluation during the course of treatment. I do not do any court related work.

[initial] **Treatment of Minors**: Children under the age of 18 must have the written consent of the legal guardian or parent. By signing this Consent for Treatment, you acknowledge that you are the child's legal guardian as established by the state or divorce decree of the minor presented. A copy of the custody agreement is requested at the first session. Most custody decrees entitle the non-custodial parent to access to health records without consent from the custodial parent.

[initial] **Emergency/On Call Services**: An emergency is a case of presence of danger to self or others, an outcry of abuse, or deterioration of your condition. In these events, you can reach me by office phone (see above) or cellular at 215-0922. In the event I am ill or out of town, a colleague will be available for emergencies.

Name of Minor ____________________ Date of Birth ____________

Name of Minor ____________________ Date of Birth ____________

****

Signature of Client/Parent/Guardian ____________________ Date ____________

Signature of Client/Parent/Guardian ____________________ Date ____________

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FINANCIAL AGREEMENT

(initial) Payment is expected at each appointment. This includes cash payment, co pays, coinsurance, and deductible. If for any reason beyond my control your insurance does not pay for your session, it is the client not the insurance company that is ultimately responsible for payment of services.

(initial) You also give permission for exchange of information between your insurance company and Patricia Carrillo Barnes and you assign your insurance benefits to Patricia Carrillo Barnes.

(initial) If you need to make payment arrangements, please talk with me at our first appointment. I can only make payment arrangements that are ethical and binding as a provider for insurance panels.

(initial) I have a confidential contract with a billing agency. This office also refers delinquent accounts to an outside collections agency for unpaid balances.

Cancellation Policy. If you must miss or cancel an appointment, please call the office as soon as possible. You must call at least 24 hours in advance of your appointment or your will be charged a "no show" fee which insurance companies do not pay and for which you are responsible.

(initial) There is a $50 fee charged for follow-up appointments that are not cancelled 24 business hours in advance – excluding weekends and holidays. Again, if we can fill your time slot with another client, you will not be billed.

(initial) Your insurance company cannot be billed for "no show" fees. You are responsible for payment. Missed appointment fees will need to be paid prior to reserving a time for any future appointments.

My signature below indicates that I have read and agree with the Financial Policy and Cancellation Policy of Patricia Carrillo Barnes, LPC, LMFT as described above.

____________________________ ______________________
Signature of Responsible Party Date

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CONSENT FOR RELEASE OF INFORMATION

Client name: ______________________________ DOB: ____________

Social Security #: ___________________________

On behalf of [ ] myself [ ] my son [ ] my daughter:
I (print name)_______________________________Please circle: client guardian
authorize **Patricia Carrillo Barnes, MS ,LPC, LMFT,** practicing at 12915 Jones Maltsberger, Suite 505, San Antonio, Tx 78247.

[] To provide information to: [] To receive information from:
[] To speak by telephone with:

____
agency/department/name

____
phone number/address

the following information:
[] Intake/Social history [] Psychological testing report [] School report
[] Clinical/treatment summary [] Termination summary[] Treatment plan
[] Other:____

for the purpose of: [] insurance claim [] continued care by another provider
[] academic placement/evaluation [] coordination of treatment
[] other: ____

[initial] I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. In any event, this consent will expire within ninety (90) days from when it was signed, upon termination of treatment, or unless another date or condition is indicated:___________________________(*indicate n/a if no condition*).
[initial] I also understand that there is a potential for unauthorized re-disclosure of the information and the re-disclosure may not be protected by federal confidentiality rules.

To the party receiving this information: This information has been disclosed to you from records, whose confidentiality is protected by federal law. Federal regulations (42CRF part 2) prohibits you from making further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for therelease of medical or other information is not sufficient for this purpose.

_______________________________ _______________
Signature of Client Date

_______________________________ _______________
Signature of parent/guardian (if client is minor) Date

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Acknowlegment of Notices of Privacy Practices

Date: _____/_____/_____

Patient Name:___________________________ Date of birth: ____/____/___

I have received and read the notice of privacy practices and understand that my health information provided to the office, will be protected in a confidential manner, as required by law. I, also understand that unless written authorization is on file, my personal file and all health information provided, including insurance information will not be released or shared with anyone. I understand that by law and without written authorization, my information may be shared if Patricia Carrillo Barnes, MS, LPC, LMFT, suspects child abuse/neglect and or danger to self or others, or should audits, inspections or investigations of administration be necessary.

_____________________________________ Date: _______________
Patient signature (guardian signature if pt. is minor)

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Emergency Contact:

Name:____ Phone:_______________

Responsible Party: (must be present to sign)

Name:____ Phone:_______________

Signature:_______________________________________ date:________________

Insurance Information:

Name of Insurance:______________________ Insured Name:___________________

Employer:___________________________ SSN:_________________ DOB:_______

ID Number:____________________ Group #:____________ Relationship:_________

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