DANIEL GARCES

Masters of Science in Counseling Psychology
Licensed Marriage & Family Therapist
Licensed Professional Counselor

FIRST APPOINTMENT CHECKLIST

Please complete the following forms and bring them to our first meeting. Doing so will maximize our time together. Otherwise, we will need to complete these forms when we meet. If you have any questions, please feel free to contact me. Or ask me when we met.

- ❑ CLIENT INFORMATION form completed.
- ❑ INFORMED CONSENT form completed.
- ❑ PRIVACY NOTICE form completed.
- ❑ AUTHORIZATIONS form completed.
- ❑ MEDICAL INFORMATION form completed.
- ❑ CREDIT CARD AUTHORIZATION FORM form completed.
- ❑ INSURANCE:
  If you choose to use your insurance benefits:
  - Services will need to be precertified:
    - You can have my billing service assist you by calling GMA Medical Billing at 713-691-7744. Inform them you need to verify your insurance to work with me. They will need: 1. Your name as it appears on your insurance card. 2. Your member or id number given on the front of your card. 3. Your group number. 4. The mental health, behavioral health or customer service number given on your card (often this is on the back of your card). 5. The name of your employer. And 6. Your date of birth. GMA will verify your benefits and fax me an insurance report.

      Or

    - You may precertify yourself by calling the mental health, behavioral health or customer service number given on your insurance card and inform them you are seeking counseling services with me. They will explain your benefits and inform you if services are in or out-of-network, if you have a deductible and/or a co-payment. If services are covered, they will provide you an authorization number for me.
  - I will need a copy of the front and back of your insurance card (we are able to make copies at the office).

Phone 713.927.7330
Fax 713.588.2403

daniel@danielgarces.com
www.danielgarces.com

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Houston, TX 77098

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CLIENT INFORMATION

DATE: ____ | ____ | ____

CLIENT: _____ SSN#: ____ | ____ | ____

BIRTHDATE: ____ | ____ | ____ EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

HOME PHONE: ____ | ____ | ____ WORK PHONE: ____ | ____ | ____

CELL PHONE: ____ | ____ | ____

EMERGENCY CONTACT

Emergency Contact Name: _____

Emergency Contact Number: ____ | ____ | ____

INSURANCE INFORMATION

NAME OF INSURED: _____ BIRTHDATE: ____ | ____ | ____

INSURANCE PLAN: _____ EMPLOYER: _____

MEMBER / ID #: _____ GROUP #: _____

Authorization for Insurance Payment: I authorize Daniel Joseph Garces, MS, LPC, LMFT and his agent(s) to release any medical or necessary information to process my insurance claims. I authorize payment of medical benefits to the undersigned supplier (i.e. Daniel Joseph Garces, MS, LPC, LMFT) for services described and rendered. I designate here that I am ultimately responsible for any and all expenses accrued

SIGNATURE OF INSURED: _____ DATE: ____ | ____ | ____

COVERAGE INFORMATION

ARE SERVICES COVERED? ____ YES ____ NO

DEDUCTIBLE: _____ MET YOUR DEDUCTIBLE? ____ YES ____ NO

CO-PAYMENT: _____ AUTHORIZATION #: _____

AUTHORIZATION UNITS: _____ PROCEDURE CODE: _____

START DATE: ____ | ____ | ____ END DATE: ____ | ____ | ____

FOR OFFICE USE ONLY

FIRST APPOINTMENT: ____ | ____ | ____ Dx: _____

NOTES:

_____ Data Entered _____ Faxed to GMA

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PRIVACY NOTICE

To comply with federal health insurance portability and accountability act guidelines Daniel Garces, MS, LPC, LMFT has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of the complete set of guidelines or download the policies from my website (www.danielgarces.com). My office holds patient record information confidential and will only use your information for treatment, payment and health care operations. The following is a partial list to whom your information can be disclosed, if needed:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers

DISCLOSING RECORD INFORMATION

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show whom the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. I will keep a record of all disclosures in your file. This information will be available for you to review.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

You can review and obtain copies of your records. Upon receipt of a written request, I will make the records available within 10 days of your request.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this privacy notice and that I may request or download a full privacy policy located online at www.danielgarce.com.

Signature _____ Date _____

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INFORMED CONSENT

Client Rights

1. Qualifications and credentials:
   A. I hold a Masters of Science in Counseling Psychology with a concentration in Marriage & Family Therapy.
   B. I am licensed by the Texas State Board of Examiners of Professional Counselors 1100 West 49th St / Austin, TX 78756-3183 / Email: lpc@dshs.state.tx.us / Phone: 512-834-6658 / My license number is #13437.
   C. I am licensed by the Texas State Board of Examiners of Marriage & Family Therapists 1100 West 49th St / Austin, TX 78756-3183 / Email: mft@dshs.state.tx.us / Phone: 512-834-6658 / My license number is #4746.
   D. I am a board approved supervisor for both of the boards listed above.
   E. I am a Faculty Member at the Houston Galveston Institute (HGI). HGI is an internationally known agency that specializes in the training of marriage and family therapists. We often have clincians training with us who are available to join me in sessions with clients. You have a right to participate in this opportunity or not. I will ask you in advance what you desire. There is no additional fee or cost to you, if these clincians join us.
2. You have a right to be treated respectfully regardless of race, creed, religion, age, national origin, physical disability, sexual orientation, gender identity or lifestyle.
3. You have a right to decide how long you stay in treatment.
4. You have a right to information about your treatment, including records. Note: your records will be destroyed in accordance with state board rules.
5. You have the right to express dissatisfaction with treatment directly to me and/or to the boards listed above.
6. You have a right to confidentiality, with certain legal and ethical exceptions:
   A. If you threaten grave bodily harm or death to yourself or another person, I may inform the appropriate authorities.
   B. If a court of law issues a subpoena or court order, the law requires the information specifically described in the subpoena be provided.
   C. If you reveal information suggesting child, elder or disabled person abuse and neglect, state law requires the reporting of this to the appropriate authorities.
   D. If you are being seen by order of a court of law, the results of treatment or tests ordered may be revealed to the court.
   E. If you authorize me and/or my agents to file a claim and bill a third party payer, then you are authorizing me and/or my agents to release any medical or necessary information to process these claims.
7. You have a right to know I may consult with other clinicians to review my work with you. With your consent, other clinicians may join our sessions.

Counseling Philosophy

My practice style emphasizes a collaborative approach towards counseling. The following statements are characteristics of this approach:

1. Clients are experts of their lives and possess the resources to achieve their goals.
2. The purposes and goals of counseling are jointly developed by the client and counselor.
3. The approach emphasizes the use of dialogue to access client resources to resolve these goals.

Financial Arrangement

1. The following is a list of current services and rates (note: services and rates are subject to change):

Service	Rate
Individual (50 min.)	$175
Family / Couple (50 min.)	$175
Group (80 min.)	$60
Supervision – Individual / Group (50 min.)	$88 / $60
Consultation (50 min.)	$175
Reports (Past 10 min.)	$100 per 30 min.

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Returned Checks	$25 per check.
Missed Appointments (Not canceled within 24 hours.)	$175 per missed appointment.
Court Appearance	$400 per hour.
Telephone Consultation (Past 10 min.)	$4 per minute.

2. Rates may vary based on contracts with third party payers. If you have any questions regarding your fee, please ask for clarification as certain restrictions and requirements apply.
3. Clients are required to give a minimum of 24 hours notice when canceling an appointment. If you provide more than a 24 hour notice, you may reschedule at no extra cost. If you cancel, no show, or reschedule with less than a 24 hours notice, then a fee of $ 175 is required. This fee may be charged to credit card on file.
4. Should you desire to use your insurance, every effort will be made to collect payment from you insurance company. However, you are ultimately responsible for the amount due.
5. Payment is due in full at each session. Payment may be made by cash, check or credit card. You may pay for services in advance. Upon request, a receipt of payment will be provided.

Emergency Policy

1. I check my voice mail and messages several times a day and can be reached by calling the main office number at (713) 927-7330. I will make every attempt to return your call within 24 hours. If you do not hear from me within this time frame, please try again.
2. If I am out of the office for an extended period, I will leave a message on my voice mail to that effect. Message left may not be returned until I return to the office.
3. In case of an emergency, you may call any one of the following emergency numbers: 911, United Way Crisis Hotline (713) HOTLINE, MHMRA Crisis Unit (713) 970-7070 or go to the nearest hospital emergency room or fire department for assistance.

Request for Services

By signing below, I am designating I have read and understood the client rights, counseling philosophy, financial arrangement and emergency policy explained above.

Client(s):	Parent (guardian) of:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____		_____

Daniel Garces, MS, LPC, LMFT

PLEASE ASK FOR A COPY IF YOU WOULD LIKE ONE.

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AUTHORIZATIONS

Please carefully read the following, mark each item "Yes" or "No", sign and date. If you have any questions, please ask for clarification.

1. I authorize Daniel Garces, MS, LPC, LMFT to contact my primary care physician (PCP) to notify and coordinate care.

____ Yes ____ No Doctor Name: _____ Phone: _____

2. I authorize Daniel Garces, MS, LPC, LMFT to contact my psychiatrist to notify and coordinate care.

____ Yes ____ No ____ N/A Doctor Name: _____ Phone: _____

3. I authorize Daniel Garces, MS, LPC, LMFT to contact my EAP or managed care referral source. I understand personal medical information (PMI) must be released to my insurance company should I choose to use my insurance benefits.

____ Yes ____ No ____ N/A Referral Name: _____ Phone: _____

4. I authorize Daniel Garces, MS, LPC, LMFT to leave a message at the phone numbers I indicated on my CLIENT INFORMATION form.

CELL ____ Yes ____ No HOME ____ Yes ____ No WORK ____ Yes ____ No

5. I authorize Daniel Garces, MS, LPC, LMFT to contact me via the email address I indicated on my CLIENT INFORMATION form.

____ Yes ____ No

6. I authorize Daniel Garces, MS, LPC, LMFT to mail correspondence to the address I indicated on my CLIENT INFORMATION form.

____ Yes ____ No

7. I authorize Daniel Garces, MS, LPC, LMFT to text message me to the cell number I indicated on my CLIENT INFORMAITON form.

____ Yes ____ No

Signature: _____ Date: ___|___|___

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MEDICAL INFORMATION

PLEASE COMPLETE FOR EACH PERSON IN COUNSELING

Name:			
Current Medications (including dosage):			
Prescribed by:			
Major Medical Events:			
Other:			

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CREDIT CARD AUTHORIZATION FORM

Please Print

Credit card billing information:		
Name:		
Email Address:		
Credit card type:	❑ Visa ❑ MasterCard ❑ American Express	
Credit Card #:		
Enter cvc #:	For Visa and MasterCard, the last 3 digits on back of card: For American Express, the 4 digits on face of card:	
Expiration Date:		
Billing Address;		
City:		
State:		
Zip Code:		
Phone Number:		
Please select one of the following payment options:		
Once	Bill my credit card once for the following amount:	$
	Bill my credit card each visit for the following amount	$
	Bill my credit card for each missed appointment for the following amount:	$ 175
Monthly	Bill my credit card once per month for the following amount:	$
I agree all information provided is accurate and complete. I also acknowledge services may be immediately terminated at Daniel Garces, MS, LPC, LMFT's discretion if any charges are declined or charge backs are claimed against any outstanding amount. Disputes to amounts should immediately be reported to Daniel Garces, MS, LPC, LMFT. Likewise, changes in the status of this card can also be reported to Daniel Garces, MS, LPC, LMFT.		
The undersigned is the dully-authorized representative of the above cardholder.		
Authorized Signature:		Date:

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3316 Mt. Vernon
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