

DANIEL GARCES
Masters of Science in Counseling Psychology
Licensed Marriage & Family Therapist - Supervisor
Licensed Professional Counselor - Supervisor

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 during our session. If you have any questions, please feel free to contact me or ask me when we met.

- CLIENT INFORMATION** form completed
- Picture ID:** Please provide a Texas driver's license/ID or a passport
- 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 pre-certified.

Option 1: Billing Service Assistance

You can have my billing service for assistance by calling **GMA Medical Billing** at **713-691-7744**. Inform them that you need to verify your insurance to receive services with me. They will need the following information:

1. Your name as it appears on your insurance card.
2. Your member or id number (listed on the front of your card).
3. Your group number.
4. The mental health, behavioral health or customer service number listed on your card (often on the back).
5. The name of your employer.
6. Your date of birth.

GMA Medical Billing will verify your benefits and fax me an insurance report.

Or

Option 2: Self-Precertification

You may precertify yourself by calling the mental health, behavioral health or customer service number listed on your insurance card and informing them that you are seeking counseling services with me. They will explain your benefits and inform you if services are in-network or out-of-network, and review any deductible and/or a co-payment requirements. If services are covered, they may provide you an authorization number for me.

Please provide a copy of the **front and back of your insurance card**.

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CLIENT INFORMATION

DATE: _____	SSN#: _____
CLIENT: _____	
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 #: _____
<p><small>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</small></p>	
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:	

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PRIVACY NOTICE

To comply with federal Health Insurance Portability and Accountability Act (HIPPA) 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 at www.danielgarces.com. My office maintains patient records as confidential and will use your information only for treatment, payment and health care operations. The following is a partial list to whom your information may be disclosed, if needed:

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

DISCLOSING RECORD INFORMATION

Release of information to any entity not listed above will requires a signed authorization from you or your guardian. This authorization must be dated and specify to whom the information is to be released or from whom it is requested, as well as the specific information to be released or obtained. Each authorization will include an expiration date. Any additional requests beyond that date will require a new authorization.

A record of all disclosures will be maintained in your file and will be available for your review.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

You can review and obtain copies of your records. Upon receipt of a written request, records will be made available within **7 business days** of your request.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this Privacy Notice and understand that I may request or download the full privacy policy located online at www.danielgarces.com.

Signature

Date

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INFORMED CONSENT

1. 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)**, an internationally known agency specializing in the training of marriage and family therapists in the **Collaborative Approach (CA)**. Clinicians in training may observe or join sessions with your consent. Participation is optional, and there is **no additional fee**.
- F. My license has **no restrictions** placed upon it by the Texas Behavioral Health Executive Council.

2. Non-Discrimination

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. Right to Self-Determination

You have a right to decide how long you stay in treatment.

4. Records and Information

You have a right to access information about your treatment, including records. Records are retained and destroyed in accordance to state board rules.

5. Complaints

You have the right to express dissatisfaction with treatment directly to me. You may also file complaints with:

Texas Behavioral Health Executive Council (BHEC)

333 Guadalupe St, Tower 3, Room 900
Austin, TX 78701
Phone: 512-305-7700
Email: enforcement@bhec.texas.gov

6. Confidentiality and Its Limits

Your information is confidential except in the following situations required by law:

- A. If you make threats of serious harm to yourself or another person, I may notify appropriate authorities.
- B. If a court orders release of information through a subpoena or court order.
- C. If you report suspected abuse or neglect of a child, elderly adult, or disabled person.
- D. If you are receiving services by court order, required reports may be shared with the court.
- E. If you authorize billing a third-party payer, necessary information may be released for claims processing.

7. Consultation

I may consult with other clinicians to ensure quality care. Identifying information is protected during consultation. With your oral or written consent, other clinicians may be present during sessions.

8. Custody of Records (Required Disclosure)

In accordance with Texas LPC Board Rule §681.35(a)(8), I have designated:

Arcenio Sarabia, Jr.
Professional Executor
Contact: **713-927-7330**

In the event of my death, incapacity, or closure of my practice, this individual will take custody of and maintain your records in compliance with state and federal law.

2. Counseling Philosophy and Approach

My practice uses a **collaborative, strengths-based, and dialogical approach**. Key principles include:

- 1. Clients are the experts on their own lives and possess the resources needed to achieve change.
- 2. Counseling goals are developed collaboratively between the client and therapist.
- 3. Dialogue is central to identifying strengths, resources, and solutions.
- 4. Common techniques may include narrative practices, systemic therapy, solution-focused conversations, emotion-focused dialogue, and reflective questioning.
- 5. As with all forms of psychotherapy, potential risks may include experiencing emotional discomfort when discussing difficult topics. Potential benefits may include improved coping, increased clarity, strengthened relationships, and reduced distress.

Phone 713.927.7330
Fax 713.588.1117

daniel@danielgarces.com
www.danielgarces.com

2990 Richmond Ave., Suite 209
Houston, TX 77098

3. Financial Arrangement

1. Current Services and Rates

Services and rates are subject to change.

Service	Rate
Individual (50 min.)	\$250
Family / Couple (50 min.)	\$250
Group (80 min.)	\$100
Supervision – Individual / Group (50 min.)	\$125 / \$100
Consultation (50 min.)	\$250
Reports (Past 10 min.)	\$125 per 30 min.
Returned Checks	\$25 per check.
Missed Appointments (Not canceled within 24 hours.)	\$250 per missed appointment.
Court Appearance	\$500 per hour.
Telephone Consultation (Past 10 min.)	\$5 per minute.

2. Insurance

Rates may vary based on contracts with insurance or third-party payers. While efforts will be made to bill your insurance, you are ultimately responsible for all fees.

3. Cancellations Policy

A minimum of **24 hours’ notice** is required to canceling or reschedule. Cancellations, rescheduling, or no-shows with less than 24 hours’ notice result in a **\$250 fee**, which may be charged to the card on file.

4. Payment

Payment is due at each session and may be made by cash, check, credit card, or Zelle. Prepayment is accepted. Receipts are available upon request.

4. Emergency and After-Hours Policy

1. I check voicemail and text messages several times a day. You may call or text me at 713-927-7330. I will make every effort to return calls/texts within **24 hours**. If you do not hear back, please try again.
2. If I am out of the office for an extended period, a message will be left on my voicemail. Calls may not be returned until I return.
3. In case of an emergency, please contact one of the following:
 3. Dial 988 – Suicide & Crisis Lifeline
 4. Dial 211 – Texas United Way Helpline.
 5. The Harris Center for MentalHealth and Intellectual and Developmental Disabilities - 713-970-7000
 6. Your nearest hospital emergency room or fire station

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 the following items. Indicate "Yes" or "No" for each, then sign and date below. 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 Employee Assistance Program EAP or managed care referral source. I understand personal medical information (PMI) must be released to my insurance company if 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 provided 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 provided on my **CLIENT INFORMATION** form.

_____ Yes _____ No

7. I authorize **Daniel Garces, MS, LPC, LMFT** to text messages to the cell phone number I provided on my **CLIENT INFORMATION** 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:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> 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 <u>once</u> for the following amount:	\$
	Bill my credit card <u>each visit</u> for the following amount	\$
	Bill my credit card for <u>each missed</u> appointment for the following amount:	\$ 250
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:	