Grapevine Behavioral Healthcare Associates
Melanie Burman, LCSW
2311 Mustang Dr. #300, Grapevine, TX. 76051 Office – (817) 481-7474 Fax – (817)416-0900

PATIENT INFORMATION

Parent/Guardian Name: (If patient is child/adolescent): _____

Last Name:_____ First Name:_____ Middle:_____

Social Security #:_____Date of Birth:_____ Gender (Please circle): Male Female

Street Address: _____

City, State, Zip Code:_____

Email Address:_____

Please list telephone numbers below that are "okay" to call:

Home:_____ Work: _____ Cell: _____

Marital Status (please circle): Single Married Divorced Other

Relationship to insured (please circle): Self Spouse Child Other

Status (please circle): Student Full-Time Student Part-Time Employed Full-Time Employed Part-Time Retired Other

If employed, name of employer:_____

Appointment Date:_____ Therapist Name: _____

Referral Source: _____

Your main concern: _____

_____

Previous Treatment or therapy: Yes _____ No _____ If yes, with: _____

_____

When? _____

Do you currently experience difficulty in any of the following?

Anxiety / Tension	Frequent Headaches	Attention Span	Guilt
Sleep Problems	Confusion	Isolation	Fears
Weakness	Depression	Dizziness	Difficulty Concentrating
Appetite Changes	Suicidal Thoughts	Memory	Anger
Nausea	Nightmares	Mood Swings	Fatigue

Alcohol Usage: _____Never_____Socially_____Occaionally_____Weekly_____Daily

DX CODE: _____

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List your current Medications:

1. Name of Medication_____ Dosage: _____ Times per Day: _____
2. Name of Medication_____ Dosage: _____ Times per Day: _____
3. Name of Medication_____ Dosage: _____ Times per Day: _____
4. Name of Medication_____ Dosage: _____ Times per Day: _____
5. Name of Medication_____ Dosage: _____ Times per Day: _____

Do you use non-prescription drugs? _____ Yes No _____ If Yes, please list: _____

_____

_____

Other people living at home: _____Age_____Relationship_____

_____Age_____Relationship_____

_____Age_____Relationship_____

_____Age_____Relationship_____

_____Age_____Relationship_____

Recent Changes: _____

_____

_____

Identify your strengths: _____

_____

_____

Emergency Contact Information

Name of Emergency Contact: _____

Relationship: _____ Address: _____

Home #: _____ Work#_____ Cell# _____

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OFFICE AND FINANCIAL POLICY

PROCEDURES AND FEES FOR CONSULTING, COACHING AND COURT ORDERED SERVICES CONT. OF OFFICE AND FINANCIAL POLICY

Melanie Burman, LCSW is named in your divorce decree, a Rule 11 agreement, A Mediated Settlement Agreement or any other court documents, or a referral from a Parent Facilitator or Parent Coordinator, and the fee for this service is **$200 per hour**. Payment is due at the time of service. Lack of payment could result in cancellation of appointments.

THE PERSON ORDERED TO PAY FOR COUNSELING SERVICES CAN MAKE PAYMENT ARRANGEMENTS BY CREDIT CARD THROUGH THE OFFICE. THIS ALLOWS THE PROCESS TO MOVE FORWARD WITHOUT INTERRUPTION. OTHER OFFICE PROCEDURES LISTED SEPARATELY APPLY AS WELL.

Melanie Burman LCSW, also provides consulting, co-parent coaching/training, co-parent support and court preparation at **$200 per hour.**

Melanie Burman LCSW charges **$200 per hour billable in 15-minute increments** for court appearances, depositions, arbitrations, including related travel and preparation, phone conferences, email, consultations with attorneys and other professionals appointed to the case as well as parent consultations.

In most cases, the payment is due prior to the services rendered. If there is not sufficient time to pay for services prior to the event, you will be invoiced with payment due **bi-monthly.**

Fees for court appearances are **$200 per hour** with a minimum of 4 hours paid in advance. If Melanie Burman is subpoenaed to court, 4 hours will be blocked from her schedule to appear unless there is a request for additional time in which 8 hours will be blocked from her schedule. If your hearing is **rescheduled**, it is your responsibility to notify Ms. Burman or the office **2 business days in advance**. If you fail to notify the office in the appropriate timeframe, you will be billed for the hours reserved for your case and these fees will not be refunded. The required fee of **$800 is due 2 business days** in advance of the hearing **unless** a full day is blocked and **$1600 is due 2 business days** in advanced. Additional fees will be billed and invoiced to you **bi-monthly** as stated above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE POLICY AND PROCEDURES FOR COURT APPOINTED SERVICES, AS OUTLINED ABOVE.

_____ _____

Print Client Name Guardian (if applicable)

_____ _____

Signature Date (mm/dd/yyyy)

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DIAL 911 FOR ALL LIFE-THREATENING EMERGENCIES

EMERGENCY TELEPHONE NUMBERS:

We are not equipped to provide emergency psychiatric treatment, but the following facilities are available for emergency services:

Baylor Hospital, Grapevine……..(817)481-1588

Denton Regional Medical Center……..(940)384-3535

HEB Springwood, Bedford……..(817)355-7771

Millwood Hospital, Arlington……(817)261-3121

Cooks Childrens Hospital, Fort Worth……..(682)885-4000

Green Oaks Hospital, Dallas……(972)991-9504

John Peter Smith……(817)921-3431

Seay Center, Dallas (children and adolescents only)……..(972)981-8300

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY AND ACKNOWLEDGE THAT I HAVE RECEIVED A COPY. I AUTHORIZE THE RELEASE OF MEDICAL AND OTHER INFORMATION NECESSARY. I WILL BE RESPONISBLE FOR ANY FEES OCCURRED. IN THE EVENT THAT MY ACCOUNT BECOMES PAST DUE, I UNDERSTAND THAT INTEREST AND COLLECTION FEES MAY BE ADDED TO MY BALANCE AND AN OUTSIDE COLLECTION AGENCY MAY BE UNTILIZED.

_____ _____

Signature of Patient or Parent/ Guardian Date (MM/DD/YYYY)

_____ _____

Printed Name of Patient or Parent/ Guardian Date (MM/DD/YYYY)

CREDIT CARD AUTHORIZATION FORM

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I._____, authorize Grapevine Behavioral Healthcare Associates to use the information and credit card numbers I have provided them to make payment for services rendered at their facility including copayment, coinsurance, No Show charges and Late Cancellation charges. If at any time, I wish to terminate this agreement, Grapevine Behavioral Healthcare Associates will be notified, and my credit card information will be destroyed.

Signed this ____day of _____, 20__

_____

Signature of Patient or Parent/Guardian

_____

Witness

Credit Card Type: (circle all that apply) MasterCard / Visa/ Discover

_____

Name exactly as it appears on the card:

_____

Credit Card Number:

_____

Expiration Date of Card:

HIPAA AUTHORIZATION FORM

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I, _____, whose date of birth is _____, authorize _____to disclose to and/ or obtain from _____ the following information:

Description of Information to be Disclosed

(Parent/ Client should be initial each item to be disclosed.)

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Testing Information
____ Educational Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Progress in Treatment
____ Other

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to _____ at time above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on _____, or as otherwise indicated: _____

Conditions

I further understand that _____will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____

_____

HIPAA AUTHORIZATION FORM

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

_____

I will be given a copy of this authorization for my records.

Signed this ____day of _____, 20__

_____

Signature of Client

_____

Signature of Parent, Guardian or Personal Representative

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. _____

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Staff Witness

_____

Date