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

Psychotherapy Appointments:

The fee for this service is **$150.00 for the initial session** and **$140.00 for each additional session**. **Group therapy session rate is $80.00**.

Additional time spent in the session will be charged on a prorated basis, however, please understand that there are other appointments scheduled after your session so extended time is unusually not available. Session time is 45 minutes, the treatment time common for psychotherapy.

Prorated charges will be made for phone consultations after five (5) minutes.

CANCELLATION POLICY: **A fee of $90 will be charged for appointments not kept or for appointments cancelled without a 24-hour notice**. It is required that this fee be paid, or payment arrangements are made prior to your appointment. Our voice mail is available 24 hours a day which allows you to leave a message at any time. Please understand that this is an office policy and is not individually negotiated by your therapist.

Excessive cancellations and missed appointments may result in loss of regularly scheduled appointment time or possibly the termination of treatment. Usually there is a waiting list of clients wanting to schedule appointments and it is important for us to accommodate these clients as well.

PAYMENT: Payment is due at time services are rendered unless other arrangements are made. Cash, Checks, Visa and MasterCard are all accepted.

Payment is expected at each office visit. In most cases, full payment is expected. Negotiated rates are required at the time of service. **There is a $35 charge for all returned checks**.

COLLECTION OF UNPAID BALANCES: A Statement of fees owed will be mailed to you as they occur. Please do not ignore these statements. Any unpaid fees may be referred to a collection agency after 45 days. If this is necessary, an additional charge of **$25** will be added to your account to cover the cost of this service.

FILE COPIES: There is a $45 charge for copying of files sent by an outside source. To release records, your account must be paid in full and appropriate release forms must be signed.

ARD MEETINGS AND SCHOOL CONFERENCES: You can request that Ms. Burman attend ARD meetings at your child's school to participate in educational planning and adjunct treatment. The fee is $200 per hours including travel time. Ms. Burman may also be available for phone conferences for the same rate

LEGAL FEES: See page 4

CONFIRMATION OF APPOINTMENTS: The office does not make confirmation calls for your appointments. Please make a note of your appointment time and date.

EMERGENCY SITUATIONS: If you are an established client and you feel you have an urgent emergency. A licensed therapist is on call for clinical emergencies at all times. The emergency phone number is 817-481-7474 when prompted press #6 and leave a message. A licensed therapist will be paged and will return your call as soon as possible

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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)

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CREDIT CARD AUTHORIZATION FORM

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.

_____

Signature of Patient or Parent/ Guardian

_____

Witness

_____

Date (date signed, OR verbal authorization gives to Grapevine Behavioral Healthcare Associates)

Credit Card (circle one): MasterCard Visa Discover

Name exactly as it appears on the card: _____

Credit Card Number: _____

Expiration Date: _____

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RECEIPT OF HIPAA INFORMATION

I hereby acknowledge that I have read and understand the PRIVACY PRACTICES notification as prescribed by HIPAA.

I understand that HIPAA places restrictions on the release of psychotherapy notes to patient or family. Further, I understand that I may request additional information by contacting the U.S. Department of Health and Human Services at (877) 696-6775.

Please list any others you authorize information to be released to:

_____

_____

_____

_____ _____

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

_____

Printed Name of Patient or Parent/Guardian

I am the (circle one) ____Patient ____Parent____ Guardian____ Other (specify) _____

_____ _____

Witness Date (MM/DD/YYYY)