

**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 \_\_\_\_\_ Occasionally \_\_\_\_\_ Weekly \_\_\_\_\_ Daily

**DX CODE:** \_\_\_\_\_

**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 \_\_\_\_\_

Recent Changes: \_\_\_\_\_

\_\_\_\_\_

Identify your strengths: \_\_\_\_\_

\_\_\_\_\_

**Emergency Contact Information**

Name of Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

## 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

**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)

**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 RESPONSIBLE 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 UTILIZED.*

\_\_\_\_\_  
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

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: \_\_\_\_\_

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:

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Signature of Patient or Parent/ Guardian

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Date (MM/DD/YYYY)

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Printed Name of Patient or Parent/Guardian

I am the (circle one) \_\_\_ Patient \_\_\_ Parent \_\_\_ Guardian \_\_\_ Other (specify) \_\_\_\_\_

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Witness

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Date (MM/DD/YYYY)

**INSURED'S INFORMATION (APPLICABLE)**

PLEASE NOTE: Parenting Facilitation services are not covered by insurance or employee assistance plans since the parent facilitation/ parent counseling is for legal, not treatment purposes.

If you have no insurance or other health coverage, and prior arrangements have not been approved, our fee for each 45 minutes session is \$140.00

Primary Last Name: \_\_\_\_\_ Primary First Name: \_\_\_\_\_

Gender: Male Female

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Email address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name of insurance carrier: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Group/Policy/Account #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY**

I hereby assign, transfer and set over to Provider all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, surgical, psychiatric and/or substance abuse (drug/alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bill if not paid by insurance company, or of any balance due payments by my insurance company.

\_\_\_\_\_  
Printed Name of Client/Guardian Date

\_\_\_\_\_  
Signature of Client/Guardian Date



Grapevine Behavioral Healthcare Associates

Melanie Burman, LCSW

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