THERAPY & LIFE COUNSELING ASSOCIATES, LLC

J. MICHAEL MURRAY, JD, MS, LMFT, LPC

New Client,

Please fill out all the paperwork in this packet and include any Employee Assistance Program (EAP) information (name of EAP company, Auth # and dates valid) if EAP applies to you.

Please complete the insurance information section **even if** EAP applies to you. This information is necessary and must be kept on file for all patients. We will need the member ID#, the group #and phone number **on the back of the card** along with the name of the insurance company.

If anything is left out we will not be able to verify the benefits and any unpaid charges will be billed directly to you.

Please be sure to sign all pages that ask for a signature. We will also need copies of the insurance card, your driver's license and the credit/debit card that you put on file (front and back of all but the D.L.)

It is best if you will scan and email, fax or mail the copies of cards and paperwork before your 1st appointment. Otherwise, please bring these items with you to your first appointment. We **must** have all of the above items, copies and completed forms by your first session.

Thank you in advance.

Signature____________________________________**Date**__________________________________

115 N. Dixie Dr, Ste. 250 Lake Jackson TX 77566;
2510 Westminster, Ste. D, Pearland TX 77581;
1458 Campbell, Ste. 200, Houston TX 77055
P-713-819-6818 F-979-292-8535;
murray@tlcassociates.org; www.tlcassociates.org

Therapy & Life Counseling Associates

J. Michael Murray JD, MS, LMFT, LPC

Client Information

Name: ______________________________ ______________________________
Last Name First Name

Address: ____

City:___________________________**State:**_______________**Zip:** _______________

Home phone ________________________ **Cell Phone** ___________________________

EMAIL: ____

Sex: (Circle One) M **F** **DOB:**__________________**Soc Sec #:** ____________________

Marital Status: (Circle One) **Single Married Separated Widowed Divorced or Child**

Place of Employment & work #:____

Who may I thank for referring you? ____

In Case of Emergency, Please Notify______________________**Phone:** ___________________

IF CHILD: Parent's name, Place of Employment and Phone number:
Mother____
Father: ____

Insurance Information:

Name of Primary Insured:__________________________________**D.O.B** _______________
Address of Primary Insured: ____
Social Security # of Primary Insured: ____

Insurance Company name: ____
Contact ph# (back of card):__________**Group #:**_____________________________________
Subscriber I.D. #: ____

EMPLOYEE ASSISTANCE PROGRAM (EAP):
EAP Authorization #: ________________________ **Contact Ph. #:**________________ **No. of sessions:**_____

I the undersigned, certify that my dependent or I have insurance coverage with:__________________and assign directly Therapy & Life Counseling Associates all insurance benefits, if any otherwise payable to me, for I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Therapy & Life Counseling Associates to release all information necessary to secure the payment of benefits. I furthermore authorize the use of this signature on all insurance submissions.

X_________________________ _____________________ **X**____________________
Responsible Party Signature Relationship Date

For Office Use Only:
Insur. Ph #_________________________Auth #/Dates_________________________________
Visits_____________DED:_______________Co-Pay:______________CPT Code(s):__________________
Claims Mailing Address:____

THERAPY AND LIFE COUNSELING ASSOCIATES

Policy Regarding Collection of:

Co-Payments, Deductibles and Denied Insurance Claims

As a client of **J. Michael Murray**, you are responsible for the payment of therapy and counseling fees. If you choose to use your health insurance coverage in connection with therapy and counseling services, the administrative staff will attempt to assist you in filing and processing such insurance claims. However, it is your insurance policy and therefore your responsibility to make sure your insurance claims are paid.

Effective March 15, 2012, fees for therapy and counseling services including co-payments, deductibles and insurance claims denied for any reason, unless otherwise provided for, will be charged against the credit card account and/or funds held on account as set forth in the Cancellation Agreement.

If for any reason we cannot charge the card on file or your account becomes delinquent, we may send to collections and you will be responsible for any fees that may apply.

************Please be advised that it is *YOUR RESPONSIBILITY* to call and cancel within 48 hours if you cann ot make it to your appointment. If you do not give enough notice, there will be a fee for a no show or late cancellation.**

X SIGNATURE____________________________________DATE___________________________

Cancellation Agreement

As either the patient in therapy, and/or the person responsible for the payment of fees in connection with counseling services, I agree that all counseling appointments made with **J. Michael Murray JD, MS, LMFT, LPC** will be kept. However if, for **ANY** reason, any scheduled appointment is not kept at the scheduled time, I agree to give **J. Michael Murray** no less than forty-eight hours advance notice. In the event such advance notice of cancellation of any scheduled appointment is not given, I agree to pay a **cancellation fee of $75.00**. I agree that the fee will be charged to the credit card account indicated below:

Visa ☐ MasterCard ☐ Other ☐ ____________________
Account Number ____
Expiration Date:__________/__________(mm/yr)
VIN Number (3 digit code on back of card):______________________Na
me of Cardholder: ____

Please print

Billing address of card: ____

____
Date: ____________________________
X Signature of Cardholder/Responsible Party: ______________________________________
Print Name: ____

I agree that I am fully responsible and will pay any fees that may be added to my account due to a late cancellation, co-pays, unpaid claims, document preparation or other fees incurred in the course of counseling services.

X SIGNATURE_______________________________DATE_____________________

THERAPY & LIFE COUNSELING ASSOCIATES

Notice of Document Preparation Fee

Effective January 1, 2012, a fee of $30.00 per page will be due and payable for all documents requested or required to be furnished by TLCA therapists. “Documents” shall include letters, statements, reports, evaluations, diagnosis, recommendations, requests for medical leave, disability findings, fitness for work evaluations, custody findings/evaluations/recommendations, and/or any other such written matters furnished by TLCA therapists.

All fees shall be due and payable at the time such Documents are furnished. Whenever necessary or required, the payment of said fees shall be subject to the same payment process as set forth in the TLCA Cancelation Agreement which has been furnished with this notice.

______________________________________ ______________________________

Signature Date

Therapy & Life Counseling Associates

J. Michael Murray JD, MS, LMFT, LPC

Client Name: ____

CONSENT FOR MENTAL HEALTH

I, the undersigned do hereby voluntarily agree to counseling services either by group individual or family counseling to be provided by Therapy & Life Counseling Associates. I am aware that the practice of counseling is not an exact science. As a consequence, I acknowledge that no guarantee has been made to me concerning the result of any evaluation or treatment that may be rendered. Further, I understand that evaluation and treatment may involve discussion of personal events in my own history that, at times, may be discomforting.

Limitations on Confidentiality:

Information about the diagnosis, evaluation, or treatment of a client with Medicaid coverage and most private health insurance plans is usually confidential information that this office may disclose only to authorized people. Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects.

The following are exceptions to confidentiality that every client needs to understand in advance.

If a counselor learns of child or elder abuse that is currently taking place or has the possibility of recurring, he or she is legally required to report that abuse to the appropriate authorities.

If a psychotherapy/counseling client discloses an intention to do something that is likely to harm him/her or others, the counselor is required to report that intention.

If a court order, other legal proceedings, or statute requires disclosure.

BASIC RIGHTS FOR ALL CLIENTS

You have the right to impartial access to treatment regardless of race, religion, sex, age ethnicity, or handicap.
You have the right to considerate and respectful treatment and recognition of your personal dignity.
You have the right to a written statement of your rights.
You have the right to be informed of your rights in language you understand.
You have the right to participate in treatment decisions.
You may terminate services at any time unless legally prohibited from doing so.
You have the right to be informed of alternatives available when you leave treatment, and you will be given specific follow up recommendations outlined.
You have the right to report any incidents of abuse or neglect, whether you are a victim or an observer.
You have the right to withdraw your permission at any time in matters to which you have previously consented.
You have the right to request the opinion of another clinician at your own expense.

Grievance Procedure or Complaints

The therapist will provide services in a professional manner consistent with all applicable laws, rules, regulation guidelines and codes of ethics and conduct concerning the therapist and the client/therapist relationship. Any dissatisfaction with services or other complaint should be discussed with the therapist.

You may also file a complaint concerning a therapist to:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834-6658

I certify that: (Check One)

________________________ I have received a copy of this document prior to treatment.
________________________ Staff has explained its content to me in a language I understand.

Signature:____ Date:________________________

Therapy & Life Counseling Associates

J. Michael Murray JD, MS, LMFT, LPC

CONSENT FOR RELEASE OF CONFIDENTIAL CLIENT INFORMATION

This consent authorizes ____
Facility/Organization/Individual Releasing Information

____
Mailing Address

to exchange the following information on ____
Client Name

From/To ____
Facility/Organization/Individual Releasing Information

120 E. Plum Angleton, TX 77515 Phone: 281-910-0921
Mailing Address

for the purpose of_insurance claim_________continued care by another physician or health care facility_____disability determination_____other (please state reason for the release) Assessment, treatment planning, continuity of care.
____

The information to be disclosed:

☐ Discharge Summary	☐ Progress Notes	☐ Vocational Assessment
☐ Psychiatric History	☐ Physician Orders	☐ Immunization Records
☐ Medical History & Physical Examination	☐ Treatment Plan	☐ Lab Findings
☐ Social History	☐ Psychological Test	☐ Radiology Reports
☐ Program Assessment	☐ Admission Note	☐ Consultation
☐ ____________________	☐ ____________________	

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and, if not revoked sooner in writing. This consent will expire 90 days from the (day signed) or (date of discharge).

To the receiving party of this information - this information has been disclosed to you for the sole purpose stated in the consent any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2).

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
Client Guardian or Authorized Representative Signature Date

______________________________ ______________________________
Therapist Signature Date