MEMORIAL RELATIONSHIPS & COUPLES CENTER, PLLC

Client Information

Client 1 _____ D.O.B_____

Address _____

Phone _____Cell _____ Email _____

Emergency Contact _____ Phone _____

Client 2 _____ D.O.B _____

Address _____

Phone _____ Cell _____ Email _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Insurance Information

Name of the insured _____ DOB _____ Relationship _____

Insurance Plan _____Employer _____

Member ID _____ Group # _____ Phone _____

Authorization for insurance payment. I authorize Rocio J. Tharp, M.Ed., LPC, LMFT and her agent to release any medical or necessary information to process my insurance claims. I authorize payment of medical benefits to the undersigned supplier (i.e. Rocio J. Tharp, M. ED., LPC, LMFT) for services described and reported. I designate here that I am ultimately responsible for any and all expenses accrued.

_____ _____

Signature of Insured Date

Coverage Information

(To be fill out by the office)

Services covered: Individual ___ Couples ___ Start Day: _____

Deductible: _____ Met the deductible: Yes ____ No ____

Co-Payment: _____ Authorization #: _____

Authorization Units: _____ DX: _____

MEMORIAL RELATIONSHIPS & COUPLES CENTER, PLLC

Consent for Counseling Services

Thank you for choosing our services. We welcome you kindly. Our goal is to offer you professional quality service. Feel free to address any questions or concerns that you may have during the sessions, including questions related to the paperwork that you are signing or any concerns related to your rights and/or responsibilities as a client. We'll be more than happy to answer them. You may be provided with a copy of all the documents for your records if you request it.

All the information in this package and within the sessions are considered confidential and will not be shared with another party without the written consent of the client.

Noted exceptions are as follow:

In case of negligence, or sexual, or physical abuse to:

- **A minor 18 years old or younger.**
- **An elderly, and**
- **A person that is considered disabled or with special needs.**
- **Or when a judge subpoenas the client's records.**

I understand that during the course of therapy I may feel worse due to the nature of the topics during the therapy sessions and that therapy does not guarantee a solution to my present situation.

I agree to the above limits of confidentiality and understand their meanings and ramifications. I understand my rights as a client, and the process to report malpractice by a therapist.

I recognized that I may receive a copy of the documents that I just signed. My signature below is giving consent to receive therapy services and that I understand the terms and limitations of the service.

My signature below indicates that I may ask for a copy of the privacy policy (HIPAA).

_____ _____

Client (1) signature Date

_____ _____

Client (2) signature Date

_____ _____

Therapist name Date

955 Dairy Ashford Rd., Suite 108, Houston, TX 77079 | 832-407-0487 | Fax 281-835-4568 | rt4@therapist.net

MEMORIAL RELATIONSHIPS & COUPLES CENTER, PLLC

Service Agreement

Our service is focused on relationships between individuals, couples, and family dynamics, as well as, group work. While the emphasis is on providing a short term counseling / consultation service, we understand that in some cases the possibility of longer term services may be needed.

During the first three sessions, we provide an assessment to better understand the client's present concerns, important relationships, family dynamic, past strategies to resolve the situation and the areas that need to be addressed first. During the first sessions the client and the therapist may determine that a referral might be needed.

The price of each 55 minute counseling session is $150.00. The price of this session will be: _____. However, the possibility of a sliding scale fee is based on your income. The cost of the session will be paid in full at the beginning of each session. The payment methods included: check, credit card, or cash. If you cannot pay for the session on time, your appointment may be rescheduled. Please let us know about any payment difficulties before the session begins.

Appointments must be canceled 24 hours in advance or you will be charged for the full amount of the session. Your insurance cannot be billed for services not rendered, therefore you will be responsible for the full contracted rate. To cancel your appointment you may call our office at (832) 407-0487, send a text message, or email at: rt4@therapist.net. For Monday appointments the cancelation will need to be the Friday prior before 5:00 pm.

If you are in a crisis and/or have suicidal thoughts, or it is an emergency, please call: 9-1-1 for immediate assistance.

Other counseling services that you may use include:

Houston Galveston Institute (Children, Adolescents & Families)…….. (713) 526-8390

Catholic Charities of Greater Houston (Individuals, Couples & Families) ……. (713) 874-6590

The Women's Center …… (713) 528-6798

_____		_____	
Client 1	Date	Therapist	Date
_____		_____	
Client 2	Date	Therapist/Supervisor	Date

MEMORIAL RELATIONSHIPS & COUPLES CENTER, PLLC

Credit Card Authorization Form

Please print

Credit card billing Information:		
Name:		
Credit card type:	☐ VISA ☐ MasterCard ☐ American Express	
Credit Card #		
Enter CVC #	For VISA and MasterCard, the last 3 digits on back of card: For American Express, the last 4 digits on the face of the card: ( )	
Expiration Date:	MONTH: _____ YEAR: _____	
Zip Code:		
Please select one of the following payment options:		
	Bill my credit card each visit for the following amount	$
	Bill my credit card for each *missing appointment* the following amount	$ 90.00-insurance $150.00-no insurance/not covered services
I agree all information provided is accurate and complete. I also acknowledge service may be immediately terminated at Memorial Relationships & Couples Center, PLLC or Rocio J. Tharp, LPC, LMFT's discretion if any charges are declined or charges backs are claimed against any outstanding amount. For any dispute any amounts should immediately be reported to Memorial Relationships & Couples Center, PLLC or Rocio J. Tharp, LPC, LMFT. Likewise, changes in the status of this card can also be reported to Memorial Relationships & Couples Center, PLLC or Rocio J. Tharp, LPC, LMFT.		
The undersigned is the dully-authorized representative of the above cardholder.		
Authorized Signature:		Date:

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MEMORIAL RELATIONSHIPS & COUPLES CENTER, PLLC

Electronic and /Digital Usage Authorization:

We value you privacy and understand that confidentiality is paramount. We do not exchange, trade or sell names, email addresses or any other pertinent information; we do not practice profiting from customer lists or anything similar.

When it comes to technological advancements in the field of communications, it has been known that these can prove to be imperfect and vulnerable to hacking. We are aware of the need of being careful in the transmission and use of the internet, email and similar means. We take precautions to care for the information and prevent unwanted inquiries; however, the risk exists.

I authorize Memorial Relationships & Couples Center, PLLC to use electronic and digital means of communication, including e-mail (electronic mail), smart phones, telecommunication and videoconferencing (like VSEE), text and instant messaging when related to my specific matters.

_____	_____	_____
Client 1 Name	Signature	Date
_____	_____	_____
Client 2 Name	Signature	Date

MEMORIAL RELATIONSHIPS & COUPLES CENTER, PLLC

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: **Memorial Relationships & Couples Center, PLLC**

Address**: 955 Dairy Ashford Rd., Suite 108, Houston, Texas 77079**

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - _____ Case notes
   - _____ Treatment Plan
   - _____ Assessment
   - _____ Diagnostic Evaluation
   - _____ Other (please specify: _____

4. I understand that the information may include behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be **disclosed to** and used by the following individual or organization.*

Name: _____

Relationship: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.

7. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____