Garcia's Family Wellness, PLLC
216 N. FM 3167, Suite #6
Rio Grande City, TX 78582
info@garciasfamilywellness.com
Phone: 956.844.3000
Fax: 956.467.4812

GFW
GARCIA'S FAMILY WELLNESS

INFORMED CONSENT FOR OUTPATIENT SERVICES CONTRACT

Welcome to Garcia's Family Wellness, PLLC (GFW) where our vision is to provide better quality of life through mental health education and exceptional care. Since this is your first visit, we hope what is written here can answer some of your questions as you seek therapy. Please let us know if you want clarification on any of the topics discussed in this Outpatient Services Contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

PSYCHOTHERAPY SERVICES

We provide psychotherapy services for children, adolescents, adults, couples and families. The first appointment(s) serves as an intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about yourself and your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help. If we do not think we are able to best assist you, we will give you names of other professionals who we believe would work well with your particular issues. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know and we will do our best to suggest a different therapist who may be a better fit.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples and family therapy sessions last 45-60 minutes (depending on your insurance benefits) unless otherwise arranged. Oftentimes, sessions are set for once each week, but this varies based on what seems most appropriate for your particular situation.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication and stability in relationships, and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Sometimes couples that come for therapy choose to end their relationships. Although there are many benefits to therapy, there is no guarantee of positive or intended results. If during your work together with your therapist, noncompliance with treatment recommendations becomes an issue, we will make effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward us, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when therapy is complete is meant to be a mutual decision, and we will discuss how to know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period of time. We may at times seek consultation with other therapists to ensure we are helping you in the most

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effective manner. We will give information only to the extent necessary, and we make every effort to avoid revealing the identity of my clients. The consultant is also under a legal and ethical duty to keep the information confidential.

MENTAL HEALTH EVALUATIONS

The testing process involves the completion of a variety of psychological assessment instruments and personal interviews. The total time of the evaluation may vary and will depend upon the questions you or the testing subject or the referral source that made the testing referral might have. The testing subject may experience emotional distress because of the personal nature of some of the information solicited by the testing process. The testing subject may interrupt or discontinue this testing process at any time.

After the testing process is completed, a report based on the results of the testing and information provided by the testing subject and others will be written. Upon your written consent to the Clinician who administered the testing, this report will be given to the person or agency that referred you or the testing subject for this service and a copy of this report will be kept in the testing subject's treatment record at GFW. An appointment with the Clinician who did the testing may be scheduled to discuss the results of the psychological testing if needed. Mental health tools, instruments, questionnaires, psychological batteries or other related materials used for testing/evaluation are copyrighted by the corresponding publishing agency and copyright protections are between GFW and the corresponding publishing agency and are used for the purposes of the evaluation. In addition, it is understood by the patient that they will not request these copyrighted materials and will defer to the evaluation report provided by GFW Clinician for corresponding evaluation results. GFW will provide a 15-minute free consultation with the patient in-person or over the phone to discuss their evaluation needs and our capacity to complete such evaluation. These may include General Mental Health Evaluations, IQ Testing, Evaluations for School, School/College Based Evaluations for Accommodations, Bariatric Evaluations, Diagnostic Clarification Evaluations, Treatment Recommendation Evaluations, Law Enforcement Candidacy Evaluations and additional evaluations not stated here. Most evaluations are completed in two separate days and on average each appointment may last 3-4 hours. We also offer concierge or home-based evaluations at an additional cost, please inquire with GFW for additional information.

Limits of Confidentiality: Like all treatment records, reports and results of psychological testing are confidential and can be released only with a written consent authorizing such release. However, if the testing subject discloses information related to suspected threats of physical harm of self or others, occurrence of child, elder, or dependent adult abuse, or if commanded by court order, GFW may be required to disclose such information to appropriate authorities or parties mandated by law.

AVAILABILITY BETWEEN SESSIONS

If needed, you can leave your therapist a message on our 24-hour voicemail box at 210-481-4265. When you leave a message, include your telephone number even if you think we already have it, and best times to reach you. We make every effort to return calls in a timely manner. In the rare occurrence that a message is missed or accidentally deleted, if you do not hear back from us within one three business days, please attempt to call us again and leave a second

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message. If we are unavailable for an extended time, such as on vacation, your therapist will inform you when they will be available again or you may call and speak with the Office Manager.

If you are in an emergency or crisis situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. GFW is not a crisis facility. Do not contact us by phone, email or fax in an emergency, as we may not get the information quickly. You may also choose to call the National Suicide Prevention Lifeline at 1-800-273-8255 or our local Bexar County Crisis Helpline number at 210-223-7233; both numbers are available 24/7.

RATES AND INSURANCE

Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits, so you understand your coverage prior to your appointment. Some insurance companies require a precertification/pre-authorization before the first appointment, or they will not cover the cost of services. We also offer flexible financing options through PayPal should you require those benefits. Please ask our Office Manager for more information at 210-481-4265.

Our current fees are as follows:

- Counseling Intake Sessions..…….... $120.00 ($150 for psychologists)
- Counseling Sessions……... $85.00 ($115 for psychologists)
- Counseling Intake Sessions with a Licensed Intern... $100.00
- Counseling Sessions with a Licensed Intern……...$65.00
- Mental Health Evaluations..……$2,500*(savings program available)
- Patients with insurance: A quote will be given to you prior to starting services

We also provide online therapy sessions via your computer or cellphone. Some health insurance carriers cover telehealth (telephone/online therapy). If your insurance plan does not cover teletherapy, it is your responsibility to pay our full rate of outlined above. Online therapy will not be available for the intake sessions.

We are happy to assist you by having our Office Manager file claims to your insurance company on your behalf. However, you, not your insurance company, are responsible for payment of the fee for therapy. Acceptable forms of payment include cash, check, major credit/debit cards, PayPal, PayPal Financing and payment is expected at the time of scheduling. Once an appointment is scheduled, the scheduling fee, outlined above, is non-refundable at any time. **CANCELLATIONS or missed appointments (no-shows) without 48 hours' notice will be subject to full fee charge, and insurance companies do not pay charges for missed appointments, these charges will be automatically processed on the card on file; this rule is not applicable to Medicaid patients.** Should you require rescheduling, please make every attempt to notify us 48 hour or more in advance. Mental health evaluations require a scheduling deposit of $200 prior to scheduling, this deposit will be applied to your deductible, copayment, coinsurance, or out of pocket expense and is NON-REFUNDABLE, if balance due is less than $200, there may be refund to the patient; this rule is not applicable to Medicaid patients. Should a Medicaid or any patient no-show or cancel their appointment prior to the 48-hour notice in an excessive amount of 3 or more times, that patient will be discharged, and the treating therapist will mail/email community counseling alternatives. If fees

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for services are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service.

We check insurance benefits as a courtesy for our clients. There are times when insurance misquotes benefits. In the event of a misquote, clients are still responsible for their copay/coinsurance/deductible amount that insurance reports after claims are submitted, unless patient is a Medicaid patient. Clients can call their insurance company to check their own benefits as well by calling the number on the back of their insurance card.

Most insurance agreements require you to authorize us to provide a clinical diagnosis and sometimes additional clinical information. If you request it, we will provide you with information to send to your insurance company. This information will become part of the insurance company's files. Insurance companies claim to keep information confidential, but you should check with your insurance company directly if you have questions about their confidentiality practices.

CONSENT TO PHOTOGRAPH

This section gives us consent to take your photograph for your electronic health records chart and for that purpose only. You photo will not be used for any other purpose and will be safely secured in our electronic health records system that is encrypted and HIPAA secured.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, our therapists do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate treatment records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information released.

CONFIDENTIALITY

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and we can only release information to others with your written permission. However, there are several exceptions, which are have indicated below. More information is provided about this in your HIPAA statement.

In judicial proceedings, if a judge orders the records released, we must release the records. In addition, we are ethically and legally required to take action to protect others from harm even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If we believe a client is a serious threat to harming him/ herself, we must take protective action (arranging hospitalization, contacting family/ significant others for notification, and/ or contacting the police). We would make reasonable effort to discuss

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any need to disclose confidential information about you, and we are happy to answer any questions you have about the exceptions to confidentiality.

MINORS

If you are under 17 years of age or younger, please be aware that the law may provide your parents the right to examine your treatment records. Your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to be discussed.

COURT RELATED SERVICES

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

- We charge a $1500 retainer prior to any preparation or attendance of legal proceedings, which will be charged on the card on file.
- We charge $600/hour to prepare for and/or attend any legal proceeding and for all court related services, which will be charged on the card on file.
- Charges for court related services are **not** covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters and may be subject to collections should the fees not be paid in a timely manner.
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

COMPLAINTS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your concerns seriously, openly, and respond respectfully. You may request to speak with the Director, Assistant Director, or Office Manager.

QUESTIONS

If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

A FINAL WORD

The counseling relationship is a very personal and individualized partnership. We want to know what you find helpful and what, if anything, may be getting in the way. We want you to feel free to share with us what we can do to help.

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Notice of Privacy Practices

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS	YOUR CHOICES	OUR USES AND DISCLOSURES
You have the right to: • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated	You have some choices in the way that we use and share information as we: • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds	We may use and share your information as we: • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

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Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

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If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Board Complaints Information:

Texas State Board of Examiners of Professional Counselors Complaint Process	Texas State Board of Examiners of Marriage and Family Therapists Complaint Process	Texas State Board of Social Worker Examiners Complaint Process	Texas State Board of Examiners of Psychologists
An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.	An individual who wishes to file a complaint against a Licensed Marriage and Family Therapist (LMFT) or a Licensed Marriage and Family Therapist Associate (LMFT Associate) may write to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.	An individual who wishes to file a complaint against a Licensed Social Worker may write to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only.	333 Guadalupe Street Tower 2, Room 450 Austin, Texas 78701 Tel. (512) 305-7700* 1-800-821-3205 24-hour, toll-free complaint system Fax (512) 305-7701 https://www.tsbep.texas.gov/how-to-file-a-complaint-enforcement#fc

Privacy Policy Consent
Garcia's Family Wellness, PLLC Privacy Policy, your signature in the following page indicates your understanding of this policy as described below.

At Garcia's Family Wellness, PLLC (GFW), your privacy is important to us. This privacy policy outlines what personal information we collect, how we use it, and who we share it with.

Information We Collect:
Personal Information: Name, phone number, email address, date of birth, and appointment details.

Health Information: Medical records, appointment notes, treatment details, and related information provided during patient care.

SMS Messaging Consent Information: Consent provided by patients opting in for SMS messaging services.

How We Use Your Information:
To schedule and confirm appointments.

To send appointment reminders and notifications via SMS messaging.

To provide patient care and related healthcare services.

To communicate important practice updates or policy changes.

To improve patient care and operational efficiencies.

Sharing of Your Information:
Your personal information and medical records are strictly confidential and shared only with authorized healthcare providers directly involved in your care.

SMS consent and mobile numbers are used exclusively for sending informational messages related to patient care. SMS consent is not shared with third parties or affiliates.

Protecting Your Privacy:
We employ industry-standard data security measures to safeguard your personal and health information against unauthorized access and disclosure.

Opt-Out and Consent Management:
You may opt-out of SMS communications at any time by replying "STOP" to any SMS message you receive from us.

For questions or concerns regarding your privacy, please contact us via our website at www.garciasfamilywellness.com.

SMS Terms & Conditions
Garcia's Family Wellness, PLLC SMS Terms of Service

By opting into SMS messaging via keyword (such as texting "START" to our designated SMS number) or web form, you agree to receive SMS messages from Garcia's Family Wellness, PLLC (GFW).

Message Types:
You will receive informational text messages, including appointment confirmations, reminders, scheduling updates, and other customer care notifications directly related to your healthcare services with us.

Messaging Frequency:
Message frequency varies depending on your appointments and patient care needs.

Message & Data Rates:
Message and data rates may apply. Please check with your mobile carrier for details.

Opting Out:
You can opt-out at any time by replying STOP to any message you receive from us. After you opt-out, you will no longer receive SMS messages unless you opt back in by replying START.

Help & Support:
If you require assistance, reply HELP to any SMS message, visit our website at www.garciasfamilywellness.com, or contact us directly at 956.844.3000

Privacy & Terms:
Please review our full Privacy Policy at https://www.garciasfamilywellness.com/privacy-policy.

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Informed Consent for Outpatient Services Contract

Please ask before signing below if you have any questions about psychotherapy or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.
Initial here if you chose to sign electronically below_____.

I have read and agree to the terms in the outpatient services contract (pages 1-5).

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Notice of Privacy Practices

I have read the notice of privacy section (pages 6-9).
Initial here if you chose to sign electronically below_____.

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

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General Health Questionnaire

Client's Primary Reason for Evaluation/Counseling Concerns:

Previous Mental Health/Substance Use Diagnosis:

Psychiatric Medications (Name, Dosage, Frequency):

History of Mental Health Treatment (Psychiatrist and Counselors):

Psychiatrist or Counselor	Date Range	Primary Reason for Treatment	Progress
Example: Dr. Jones, Psychiatrist	05/2019-Present	Depression	Mild progress on medications.
Example: Dr. Jane, LPC	05/2019-Present	Anxiety	Feel the same, no progress.

Psychiatrist or Counselor	Date Range	Primary Reason for Treatment	Progress

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Previous Physical Health Diagnosis:

Physical Health Medications (Name, Dosage, Frequency):

Any Known Allergies:

Additional Information:

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Demographic Information

Client Legal Name:	Date:
Client Preferred Name:	Preferred Pronouns (He/His/Him):
Legal Sex: ☐ M ☐ F *While GFW recognizes a number of genders / sexes, many insurance companies do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.	
DOB:	Email:
Parent/Guardian's Name(s):	
Address (City, State, Zip Code):	
Additional Email:	
Best number to reach you:	May we leave a message? ☐ Yes ☐ No
Policy Holder Name:	DOB:
Relationship to client:	

Emergency Contact/Guardian Information

Name:	Relationship to client:
Address:	Phone Number:

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Insurance Information

☐Check here if no insurance will used (do not proceed with below insurance information).

PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS (FRONT AND BACK)

Primary Insurance Name:	Insurance Primary Holder Name:
Legal Sex: ☐ M ☐ F	Date of Birth
Phone Number:	Address:
Member ID:	Group Number:
Insurance Phone Number:	Insurance Fax Number:
Insured's Employer:	
Relationship to client:	
Secondary Insurance Name:	Secondary Insurance Primary Holder Name:
Legal Sex: ☐ M ☐ F	Date of Birth
Phone Number:	Address:
Member ID:	Group Number:
Insurance Phone Number:	Insurance Fax Number:
Insured's Employer:	
Relationship to client:	

Garcia's Family Wellness, PLLC
216 N. FM 3167, Suite #6
Rio Grande City, TX 78582
info@garciasfamilywellness.com
Phone: 956.844.3000
Fax: 956.467.4812

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____ hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked** to be included in the use and/or disclosure of other health information:

☐ HIV/AIDS related treatment ☐ Mental health information ☐ Psychotherapy notes

☐ Sexually transmitted diseases ☐ Drug/alcohol diagnosis, treatment/referral

to _____, _____
(receiving Agency/person) (Address, City, State, Zip Code)

for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care ☐ Therapist transition

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other _____

This consent is valid for 12 months unless specified here:_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

Initial here if you chose to sign electronically below_____.

_____ _____
Adult Client Name or Legal Guardia/Parent Name Signature of Adult Patient Or Parent Date

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

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CREDIT CARD ON FILE

Payments are due at the time of service. GFW **requires** a credit, debit, or flex spending/HSA card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged our full fee on the day of scheduled session). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

☐ Please charge my card for charges in full for sessions at the time of service.

Client Name:		
Cardholder Name:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:
Initial here if you chose to sign electronically below_____		
Cardholder's Signature:		Date:

I understand that by signing above, I am authorizing GFW to charge my card in the manner indicated by my signature above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancellation fees.