Marie Denise Guillory, M.Ed., LPC
6026 85th St
Lubbock, TX 79424

Phone: (806) 939-5673 **www.ccslubbock.com** **Fax: (806) 798-0823**

PERMISSION, UNDERSTANDING, AND ACKNOWLEDGEMENT

Permission to Treat:

1. By my signature below, I _____ give permission to Marie Denise Guillory, LPC to treat/evaluate myself, or if applicable, my dependent named _____.

Understanding of Client's Rights & Office Policies:

1. With regard to the office of Marie D. Guillory, LPC, I acknowledge I have read and understand the following documents, have been offered a copy, and can ask questions at any time.
    a. Cancellation Policy dated 09/26/22
    b. Limits of Confidentiality dated 09/26/22
    c. Notice of Privacy Practices dated 09/26/22

2. With regard to the office of Marie D. Guillory, LPC, I understand all policies regarding: Ethics; Confidentiality; Cancellations & Missed Appointments; and Release of Records discussed in the above documents.

_____ _____
Signature – Client Date

_____ _____
Marie Denise Guillory, LPC Date

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CLIENT INFORMATION – PAGE 1 of 2

DATE OF INITIAL CALL TO OUR OFFICE: _____

CLIENT NAME: _____ DOB: ____-____-_____

GENDER: ❑ Male ❑ Female EMAIL: _____

PHONE: Cell _____ Home _____ Work _____

SS#: _____-_____-_____ DL #: _____ DL STATE: ___

ADDRESS: _____
_____

CITY: _____ STATE: ___ ZIP: _____

EMPLOYER: _____

WILL CLIENT BE USING INSURANCE? ❑ Yes ❑ No EAP?: ❑ Yes ❑ No
EAP Company & Tele: _____
EAP VISITS: _____ EAP AUTHORIZATION#: _____
EAP START DATE: ____-____-_____ EAP END DATE: ____-____-_____

SUBSCRIBER NAME: _____ DOB: ____-____-_____
RELATIONSHIP TO CLIENT: _____

GENDER: ❑ Male ❑ Female

PHONE: Cell _____ Home _____ Work _____

SS#: _____-_____-_____ DL #: _____ DL STATE: ___

ADDRESS: _____
_____

CITY: _____ STATE: ___ ZIP: _____

EMPLOYER: _____

INSURANCE CARRIER: _____ TELE: _____

ID#: _____ GROUP: _____

NOTE: Insurance benefits information obtained from the Clients Insurance company by Marie Denise Guillory, M.Ed.,LPC's staff is not a guarantee of benefits. All benefits are subject to the terms, limits, and exclusions under the members policy on actual date of service.

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CLIENT INFORMATION – PAGE 2 of 2

EMERGENCY CONTACT: NAME / PHONE / RELATIONSHIP TO CLIENT:
_____

WHO REFERRED YOU TO THIS OFFICE? _____

CONTACT METHODS

I prefer to be contacted using the following methods: (check all that apply)

_____ Home Telephone: _____
- _____ Acceptable to leave a detailed message
- _____ Leave message with call back number only
- _____ Acceptable to fax to this number

_____ Work Telephone: _____
- _____ Acceptable to leave a detailed message
- _____ Leave message with call back number only

_____ Cell Phone: _____
- _____ Acceptable to leave a detailed message
- _____ Leave message with call back number only

_____ _____
Signature – Client Date

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STATEMENT OF UNDERSTANDING REGARDING CHARGES FOR MENTAL HEALTH SERVICES

I (*Client Name*): _____
(*Address*): _____
(*Phone*): _____
am the person financially responsible for payment for mental health services when they are rendered to me by Marie Denise Guillory, LPC

If Client is uninsured at the time of service, I understand I am responsible for 100% of the mental health services.

If Client is insured, we will submit a claim to your insurance company as a courtesy to you. However, the client is required to provide the correct Insurance information and obtain referrals, if required by their Insurance company, prior to the appointment. Additionally, I understand I am responsible for payment of copays, coinsurance, deductibles and mental health services not covered by the Client's insurance company or EAP (Employee Assistance Program) sessions at the time the services are rendered.

I understand Employee Assistance Program (EAP) sessions are no cost to me as long as the sessions occur within the effective date range and do not exceed the allowed number of sessions.

With the exception of payments made by or due from insurance that covers mental health services, I understand that my part of the bill for these services is in default 30 days after the services are rendered. When insurance refuses to cover these charges, the bill is in default 30 days after the insurance declares the bill to not be covered by insurance. If the bill is in default for 60 days, and no payment arrangements have been made, then the bill will unfortunately be turned over to collections.

I understand and agree that I shall be liable for any and all collection expenses should my bill for mental health services come into defaults

_____ _____
Signature – Client Date

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CARD AUTHORIZATION FORM

CLIENT NAME: _____

DATE OF BIRTH: _____

The purpose of this form is to authorize Marie Denise Guillory, LPC to retain a valid credit/debit card number on file for you as our client. All new clients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit/debit care will be charged ONLY under the following circumstances:

1. Marie Denise Guillory, LPC reserves the right to charge the credit/debit card listed on page 2 for all current clients balances, including co-pays. A receipt will be kept in your client chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current client balances on your account.

2. If you, as the client, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Marie Denise Guillory, LPC reserves the right to charge the credit/debit card listed on page 2 $150.00 for our standard no-show fee. A receipt will be sent to the current address file. This notice serves as your consent to being charged for any and all no-shows.

3. If we receive notice that a payment is returned to us for any reason, Marie Denise Guillory, LPC reserves the right to charge the credit/debit card listed on page 2 a $25.00 returned check fee as well as the amount of the issued insufficient check. A receipt will be sent to the email address on file. This notice serves as your consent to being charged for any returned payments.

4. Other than the conditions mentioned above, under NO circumstance will Marie Denise Guillory, LPC charge your credit/debit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit/debit card information will be confidentially & securely kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:

My signature below acknowledges that I have read this form, and give my authorization and consent to provide the requested information --on page 2-- for my credit/debit card to be charged for the conditions listed above, plus a Card Convenience fee of approximately 5%.

_____ _____
Signature - Client or Responsible Party Date

_____ _____
Marie Denise Guillory, LPC Date

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CARD AUTHORIZATION FORM

NAME, AS IT APPEARS ON CARD: _____

BILLING ADDRESS: _____

_____

AMEX/DISC/MC/VISA CARD# (LAST 4 DIGITS ONLY): ___ ___ ___ ___
NOTE: The complete number will be obtained at your 1st appointment.

EXPIRATION DATE: _____/_____

VERIFICATION CODE (3 or 4 DIGITS): ___ ___ ___ ___