Laura Mangin McDonald, MA LPC
Christian Counseling & Therapy

7502 Stone Hill Court
Garland, TX 7502-2408
214.676.6501

CLIENT INTAKE AND INFORMATION FORM AND COUNSELING POLICIES

PATIENT INFORMATION

Name	Date of Birth
Address	Gender ☐ Male ☐ Female
Parent/Guardian (for Minor Patient)	☐ Parent ☐ Guardian ☐ Other
Contact Phone Number	Leave Msg? ☐ Yes ☐ No
Contact E-Mail	May We E-Mail You? ☐ Yes ☐ No
Emergency Contact Name	Phone Number
Primary Care Physician	Phone Number
Referred By	SSN:

FEE SCHEDULE

Description	Time Unit	Fee
Initial Intake Session	2 hours	$250
Individual Therapy Session	60 minutes	$125
Couple/Family Session	60 minutes	$125
Group Session	by agreement	*
Telephone Session	up to 60 minutes	$125
Late Cancellation/No Show	—	$125
Phone Calls	15 minute increments	$25 per 15 minutes
Letters & Reports	by agreement	†
Court Appearances	per hour	$300
Retainer for Court Appearance	—	$1,500‡
Returned Check (NSF)	—	$30
Photocopy Charges	—	$0.25 per page

* - Group sessions are subject to agreement of all participants and fees will vary depending upon the number of participants and the number of sessions.

† - The fee for general correspondence letters is $50. The fee for one or more reports requested or required will be set in advance, as determined by the nature of the report and my best estimate of the time and complexity.

‡ - The retainer must be received prior to work commencing. All work will be billed against the retainer. When the retainer balance reaches $400 the balance must be brought back to $1,500. Any balance remaining after the conclusion of the matter will be refunded, without interest. Fees paid are not refundable if the matter settles or I am otherwise not ultimately called upon to attend a trial or hearing or testify, or if materials I have prepared are not used.

Laura Mangin McDonald, MA LPC
Christian Counseling & Therapy

7502 Stone Hill Court
Garland, TX 7502-2408
214.676.6501

SIGNATURES

By my signature below, I (i) confirm the accuracy of the Patient Information listed on page 1, (ii) acknowledge and agree to the counseling fee schedule set forth on page 1, and (iii) understand my responsibility to update Patient Information in the event it should materially change. I understand my responsibility for payment of services rendered or contracted for. If I am the parent or guardian of a minor child I acknowledge my responsibility for payment in full for all services provided to or contracted for that child. I understand that unless other arrangements have been made in advance, payment in full is due and payable at the time of service. Any outstanding balance is payable in full upon termination of treatment for any reason.

Patient Name:	
Patient Signature:	Date:
Parent/Guardian Signature:	Date:

INFORMED CONSENT

By my signature below, I consent to treatment, or consent to treatment of my minor child, pursuant to the terms and conditions set forth in (a) this Client Intake and Information Form, (b) Counseling Practices and Policies, (c) the Authorization to Release Information, and (d) the Notice of Privacy Practices (HIPAA), each of which I acknowledge I have received and read, or have had the opportunity to have read. I understand that if I have any questions, concerns or complaints regarding treatment or this practice, I may contact the Texas Department of State Health Services toll free at 1-888-963-7111 or by email at customer.service@dshs.tx.us.

Patient Name:	
Patient Signature:	Date:
Parent/Guardian Signature:	Date: