P. Troy Gremillion, MA, LMFT, LPC, NCC
Troy Gremillion, LLC
COUNSELING, PSYCHOTHERAPY, WORKSHOPS
INDIVIDUALS, COUPLES AND FAMILIES
8831 Long Point Road ♦ Suite 202
Houston, Texas 77055
Telephone: 713-492-5420 ♦ Facsimile 832-582-6071
E-mail: ptroygremillion@gmail.com
www.ptroygremillion.com

CONTACT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Date of Birth: _____

Age: _____

SS Number: _____

Driver's License Number: _____ State: _____

Occupation: _____

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

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INFORMATION FOR CLIENTS

Welcome and thank you for choosing me for your psychological health care. I assure you that I will work with you in a caring and professional manner. Please take a few moments to read my office policies as set forth herein, and do not hesitate to ask any questions that you may have. *By signing this document, you acknowledge that you have read it and will honor my offices policies as outlined below.*

Please be sure to bring this COMPLETED Client Intake Form and Adult or Teen Questionnaire (whichever is applicable) to the FIRST appointment. Otherwise, your session will be delayed or will need to be rescheduled until all paperwork is completed.

If you choose to E-mail me your paperwork, please password protect it!

OFFICE HOURS: My office hours fluctuate with my appointments. I will work with you to schedule a mutually agreeable time. I have a limited number of evening hours available.

FEE SCHEDULE:

- **Psychotherapy Sessions for Individuals, Couples and Families:**

  Individual Session - 50 minutes @ $225 or 80 minutes @ $360

  Couples Session - 50 minutes @ $250 or *80 minutes @ $400

  Family Session - 80 minutes @ $400

  **Extended sessions are especially recommended for couples therapy.*

- **Group Psychotherapy Session:** 80 minutes @ $90 (groups are limited to 8 members)

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- **Payment:** As part of the *Cash Discounting Program*, payment for therapy sessions are to be made by check, cash, Venmo, or Cash App. A credit card number is **required** to guarantee payment for telephone/videoconference sessions, for cancellations made with insufficient notice (less than 48 hours) and No Show appointments, or for accounts delinquent more than 30 days. Completing the Credit Card Pre-Authorization Form on the last page of this form is a **requirement** for treatment. *A fee of $25 will be charged for all returned checks.*
- **Telephone/Videoconference Sessions:** Telephone and videoconference sessions are offered. Typically, telephone calls are permitted for purposes of rescheduling or canceling appointments. However, if a telephone call lasts longer than five minutes, you will be billed in 15-minute increments, pro-rated on an hourly rate of $250.
- **Additional Fees:**
    - For paper copies of your medical records, you will be charged $25 for the first 20 pages, and 50 cents for each page thereafter. For records provided in an electronic format (if applicable), you will be charged $25 for the first 500 pages and $50 for more than 500 pages.
    - Preparation time for additional reports, forms or documents required by you, your insurance company, or any other party, will be billed at the hourly rate of $250 and will be calculated in 15-minute increments. Upon such requests, your written consent will be required before providing that service.
    - Additional fees will apply for clinical consultations with other treatment (or legal) providers and will only be conducted with your written consent and will also be billed at the hourly rate of $250 and will be calculated in 15-minute increments.
    - Additional fees may also apply if you request that your therapist review documents, correspondence, articles, books, video or audio recordings, websites, et al., outside of your session time for the purpose of discussion or feedback in or out of a session. This time will also be billed at an hourly rate of $250 and will be calculated in 15-minute increments. (Please note that your insurance company will not cover any service provided to you outside of your session time, so you will be responsible for full payment related thereto.)

INSURANCE/MANAGED HEALTH CARE: I do not accept insurance or managed health care plans. However, if requested at the beginning of treatment, I will provide you with a superbill at the end of each session for reimbursement from your insurance company, FSA/HSA administrator, or for tax purposes. Requesting a superbill after services have already been provided or terminated will incur an additional fee, per the Additional Fees section above.

ATTENDANCE POLICY: Attending scheduled appointments is critical to the success of counseling. If missed or late-cancelled appointments become a concern, I will initiate a conversation about how to remain engaged in services. I may request that an attendance contract be discussed and signed. If attending regular appointments continues to be an issue, I reserve the right to terminate treatment and will provide you with referrals if requested.

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CANCELLATION/NO SHOW FEE POLICY: Please understand that by scheduling an appointment, you will have reserved an hour (or more, as scheduled) of my clinical time. If you do not show up for your scheduled appointment, and you have not notified me at least **48 hours** in advance of your scheduled appointment that you are cancelling it, you will be required to pay the full cost of the treatment as booked before another appointment will be scheduled (see **Fee Schedule**). *In the event that you cancel your Initial Consultation without 48 hours' notice or you no show to your Initial Consultation and you wish to reschedule it, you will be required to pay the session fee in full at the time it is rescheduled.* **Please be advised that the sliding-scale fee will not be honored in the case of a late cancellation (less than 48 hours notice) or "No Show" appointment (see Late Arrival Policy below). As such, you will be responsible for paying the full cost of the session as booked before another appointment will be scheduled** (see **Fee Schedule**). ***Please initial here to indicate you have read and understand this policy:_____***

LATE ARRIVAL POLICY: In order to ensure that your time is respected and waiting time does not interrupt your schedule or mine, every effort is made to start and stop on time. If you have not arrived by 15 minutes after your scheduled appointment time and you do not contact me before or within the first 15 minutes of your appointment time, your appointment time will be forfeited and will be deemed to be a "No Show" appointment. **As such, you will be responsible for the full cost of the session as booked, per the fee schedule above.** As this is your time, please remember that it is important to be on time for your appointment. ***Please initial here to indicate you have read and understand this policy:_____***

INCLEMENT WEATHER/FORCE MAJEURE POLICY: While therapy sessions will typically take place in my office, *unless a client has originally sought online therapy*, in the event of inclement weather or unforeseeable circumstances that prohibits a client from getting to my office, the session scheduled on any day when this is the case will be conducted virtually via Zoom, which is a HIPAA-compliant software. It is your responsibility to download (on computer, phone and/or handheld device) and test the software in advance of such emergency situations. It is also your responsibility to inform me (via telephone, text or email) that you will be unable to attend your scheduled session in my office due to inclement weather or unforeseeable circumstances. Upon such notification from you, I will generate the Zoom videoconference call to you at your scheduled appointment time. In the event there is inclement weather or unforeseeable circumstances on the day on which you have a scheduled appointment, please use your best judgment when deciding whether to attend a session in my office. *Remember, your safety comes first!* ***Please initial here to indicate you have read and understand this policy:_____***

E-MAIL, TEXT MESSAGING AND FAX COMMUNICATION POLICY: I do not discuss therapeutic issues via E-mail or text. However, I will E-mail logistical information related to appointment scheduling or, from time to time, to recommend an article or book I think may be helpful in your treatment. Only emails under 150 words are read, due to the time constraints of a busy practice. Please keep your query brief and to the point. If you send me an E-mail message between appointments related to therapeutic issues, please understand that I will use your session time to address them and will not respond to them via E-mail. *It is very important to be aware that E-mail and cell phone communication can be relatively easily accessed by unauthorized parties;*

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as such, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all E-mails that go through them. Because I cannot ensure your confidentiality via cellular service and to remain HIPAA compliant, I absolutely require that the use of text messaging be reserved for the sole purpose of communicating logistical information (i.e., scheduling or rescheduling appointments, running late for your appointment). Please take special care to ensure that you are faxing any personal information to the correct fax number. Lastly, I require written notification at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned electronic communication methods. Additionally, if you choose to send this Client Intake Form or any other personal/protected information via E-mail, you are required to password protect it. If you do not password protect your personal/protected information that is sent via E-mail, please be aware that you bear the sole responsibility for any access to that personal/protected information by unauthorized parties.
Please initial here to indicate you have read and understand this policy:_____

NOTICE OF PRIVACY PROCEDURES: I am required to: (i) maintain the privacy of your health information, (ii) provide you with a notice as to our legal duties and privacy practices with respect to information I collect and maintain about you, (iii) abide by the terms of this notice, (iv) notify you if I am unable to agree to a requested restriction, and (v) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

AVAILABILITY/EMERGENCIES: If you are experiencing a life-threatening emergency, you are urged to go immediately to the nearest hospital emergency room or 24-hour care center, or to call 9-1-1.

CONFIDENTIALITY: All information disclosed within psychotherapy sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without the client's written permission, except where disclosure is required by law.

- **Disclosure required by law:** Some circumstances requiring disclosure exist when there is reasonable suspicion of child, dependent, or elder abuse of neglect; when a client presents a danger to self, others, property, or is gravely disabled.
- **Disclosure may be required by law:** Disclosure may be required pursuant to a legal proceeding. Placing your mental status at issue in litigation initiated by you may give the defendant the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information.
- **Health Insurance:** Your health insurance carrier may require confidential information to process a claim. Although only the minimum necessary information will be communicated to the carrier, I have no control or knowledge over the use or disclosure of such information once it is in the possession of the insurance companies.

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YOUR RIGHT TO REVIEW RECORDS: You have the right to review or receive a summary of your records, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful to you in any way. In such case, I will provide the records to an appropriate mental health professional of your choice.

CONSULTATION: Best practices in the counseling profession dictate that I consult regularly with other professionals regarding clients and their issues; however, please be assured that a client's name or other identifying information are never mentioned, and anonymity and confidentiality are fully maintained.

THE PROCESS OF THERAPY/EVALUATION/CONSULTATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships, and resolution of the concerns that led you to therapy. Psychotherapy requires active involvement, honesty, and openness in order to change thoughts, feelings, and/or behaviors. In the course of psychotherapy, remembering or talking about unpleasant events, feelings, and thoughts can result in considerable discomfort and strong feelings of anger, sadness, fear, confusion, etc.; or the experience of anxiety, depression, insomnia, frustration, etc. Additionally, challenging your assumptions, perceptions, beliefs and behaviors may also cause discomfort and uncertainty at times. With couples and families, the changes that occur in one client may result in discomfort for another, and generally couples and families do better if all are involved in psychotherapy. Change will sometimes come quickly, but most often, it is slow and gradual, and there is no guarantee that psychotherapy will yield the intended results.

TERMINATION: I do not accept clients whom I do not believe I can help, and will offer referrals if that seems advantageous, and will participate in transition to another mental health professional if needed. You have the right to terminate treatment at any time and are encouraged to discuss termination plans well in advance. I reserve the right to terminate treatment if a client's attendance becomes an issue, if a client behaves with me in a financially unsavory or irresponsible manner, or if a client becomes sexually provocative or inappropriate.

MEDIATION AND ARBITRATION: Disputes arising out of or in relation to the agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by mutual agreement between me and the client. The cost shall be divided equally unless otherwise agreed. In the event the mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Harris County, Texas, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. **Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, attorneys, collection agency, etc.) to obtain payment. Accounts not paid within 30 days of the date of the invoice are subject to a .83% monthly finance charge. Any account more than 90 days delinquent will be turned over to an attorney whom I retain to collect fees from former clients who have behaved with me in a financially unsavory or irresponsible manner. I further reserve the right to report the delinquency to the three major national credit bureaus (TransUnion, Experian, and Equifax). The prevailing party in arbitration or a collection proceeding shall be entitled to recover a reasonable sum for court,**

collection and attorneys' fees. In the case of arbitration, that sum will be determined by the arbitrator.

LITIGATION LIMITATIONS: Due to the sensitive nature of the disclosures required in the therapeutic process, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither the client nor his/her attorney, nor anyone else acting on your behalf, will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICIES AND CONDITIONS OF THERAPY AS STATED ABOVE.

_____

Electronic Signature of Client (or person acting for client) Date

_____

Printed Name Relationship to client (if necessary)

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CONSENT FOR TREATMENT

I acknowledge that I have received, have read (or have had read to me, and understand the "Information for Clients" section of these forms and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist, P. Troy Gremillion, MA, LMFT, LPC, NCC (hereinafter Mr. Gremillion). I understand that developing a treatment plan with Mr. Gremillion, and regularly reviewing our work toward meeting the treatments goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Mr. Gremillion.

I am aware that I may stop my treatment with Mr. Gremillion at any time. The only thing I will still be responsible for is paying for the services I have already received, including late cancellation and no show fees. I understand that I may lose other services or may have to deal with other problems if I stop treatment (e.g., if my treatment has been court-ordered, I will have to answer to the court..

I understand and agree that I must cancel an appointment at least 48 hours before the time of the appointment. I also understand and agree that if I do not cancel an appointment with appropriate notice or do not show up for my appointment, I will be charged for that appointment (as booked) and payment for it will be required before another appointment will be scheduled.

I am aware that an agent of my insurance company or other third-party may be given information about the type(s, cost(s, date(s, and provider(s of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Mr. Gremillion may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____
Electronic Signature of Client (or person acting for client) Date

_____
Printed Name Relationship to client (if necessary)

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I, P. Troy Gremillion, MA, LMFT, LPC, NCC (Troy Gremillion, LLC) have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of P. Troy Gremillion, MA, LMFT, LPC, NCC Date
Troy Gremillion, LLC

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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CREDIT CARD PRE-AUTHORIZATION FORM
****COMPLETING THIS PAGE IS MANDATORY BEFORE TREATMENT WILL BE PROVIDED****

I hereby authorize Troy Gremillion, LLC (hereinafter Troy Gremillion) to keep my signature and credit card number on file and to charge my credit card account for psychotherapy services provided to me, to a minor child or to any individual(s) for whom I accept financial responsibility. I further authorize Troy Gremillion to charge the credit card listed below for telephone/videoconference sessions, for cancellations made with insufficient notice (less than 48 hours), and for "No Show" appointments for the full cost of the session as booked, per the Fee Schedule on page 2 of this form.

If a sliding-scale rate is offered to me, a minor child or to any individual(s) for whom I accept financial responsibility, I authorize Troy Gremillion to charge the credit card listed below in the amount of $_____* (write in "N/A" if not offered a sliding-scale rate) for telephone/videoconference sessions.
Please be advised that the sliding-scale rate does not apply in the case of a late cancellation or "No Show" appointment. As such, you will be responsible for the full cost of the session as booked, per the Fee Schedule on page 2 of this form. Please initial here to indicate you have read and understand this policy:_____

I further authorize Troy Gremillion to charge the credit card listed below for any balance on an account for which I assume financial responsibility that is delinquent more than 30 days or for any outstanding balance that remains upon termination of treatment provided to me, a minor child or any individual(s) for whom I assume financial responsibility.

I understand that should I decide to terminate any of the services and my account is paid up in full, I may withdraw the authorization to charge my credit card in the future provided I communicate revocation of authorization in writing to Troy Gremillion by mail or fax. I further authorize Troy Gremillion to charge my credit card using internet-based credit card transaction services, and I understand that use of said credit card transaction service does not constitute a violation of confidentiality.

Client's Name:_____

Responsible Party:_____

Cardholder's Name:_____
(as it appears on the credit card)

Billing Address:_____

City, State, Zip Code:_____

Credit Card Type ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number:_____

Expiration Date:_____ Security Code:_____

Today's Date (month/day/year):_____ Email:_____

Telephone (on file with credit card company):_____

Electronic Signature:_____

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