Koinonia Christian Counseling

Welcome to *Koinonia Christian Counseling*! The counseling you will receive here is Biblically based and focused on heart change. It is my hope and prayer that your life will be forever changed by the transforming power of God's Word. Together we will work towards a solution for whatever problem has brought you here. It is my hope through the power of the Holy Spirit that you will experience real transformation and healing.

Confidentiality: Defined as keeping private the information shared between client and his/her counselor. Everything spoken here is protected by the confidentiality statutes of the State of Texas. *Koinonia Christian Counseling* will in no way disclose any information without your written consent except in the following situations: (a) If physical or sexual abuse or neglect of minors is reported by you or your child, a report must be made to the appropriate authority; (b) if abuse, neglect or exploitation of the elderly or disabled is reported by you or your child, a report must be made to the appropriate authority; (c) if you threaten grave bodily harm to yourself or another person, your counselor is required by ethical standards to inform the intended victim and/or the appropriate law enforcement agencies; (d) if your counselor is required by a court of law (court order) to turn over records to the court or is ordered to testify regarding those records.

Appointments: Counseling sessions are 45-50 minutes. Counseling is a joint effort between the counselor and the client, for it to be effective several things are required. Clients need to be committed to attending faithfully and willing to complete "homework assignments" between sessions. Establishing clearly defined goals (counselor will help do this in the first couple of sessions). Willingness to accept the truth as found in God's Word, and integrate it into your life. If you should need to cancel an appointment *Koinonia Christian Counseling* requires 24 hour notice. The counselor reserves the right to bill for the session if less than 24 hours notice is given.

Financial Policy: The standard fee for services provided by *Koinonia Christian Counseling* is $140.00 for the initial session and $125.00 per session thereafter. Payment is due when services are rendered, at the end of each session. *Koinonia Christian Counseling* will agree to file insurance claims, even on out-of-network mental health benefits if the client has applicable insurance coverage. **It is the client's responsibility to verify eligibility. It is the client's responsibility to know what their insurance policy covers and to make sure the deductible is met.** The client is responsible for any co-payments, deductibles, and non-allowed charges. Until an EOB / payment has been received from the insurance company fees (in full) will be collected at time of service.

If client is under 18, I _____ (please print), have legal custody and give my consent for counseling of the above named minor. If client is a child / children of divorce, *Koinonia Christian Counseling* will need a copy of the divorce decree showing the legal custodian of the child / children.

_____

Signature of Parent or Guardian

All members of your family who are involved in counseling need to sign below, indicating understanding of these policies and procedures.

ACKNOWLEDGED:

Date:_____ Client's Signatures: _____

_____

Counselor: _____

Koinonia Christian Counseling

6021 Morriss Road Suite 109A Flower Mound, TX 75028; Phone# (940) 783-8135

Client Information

Today's Date: _____

First Name: _____ M.I.: _____ Last: _____ M ☐ F ☐

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____

SS#: _____ Email: _____ Drivers Lic. #: _____

Phone: ( ) _____ ( ) _____ ( ) _____ D.O.B. __/__/__
Home Work Cell

Referred by: _____ Church Affiliation: _____

Spouse / Guardian / Parent Information (Circle one):

First Name: _____ M.I.: _____ Last: _____

Address (if different than Client): _____

SS#: _____ Email: _____ D.O.B. __/__/__

Phone: ( ) _____ ( ) _____ ( ) _____
Home Work Cell

Dependants (Names & Ages): _____

Insurance Information

(Please present insurance card with this form to be photocopied)

Named of Insured: _____ SS#: _____

Insured's DOB: __/__/__ ID#: _____ Group #: _____

Insurance Carrier: _____ Insurance Plan: _____

Address: _____

Benefit/Eligibility Phone Number: ( ) _____ Deductible:

Insured Employer: _____ Telephone: _____

Address: _____

I authorize the release of any medical or other information necessary to process this claim.

I hereby authorize the insurance carrier listed above to make payments directly to the provider of services and understand that I am financially responsbile for all charges that are not covered or are declined by my insurance company.

_____ _____

Insured's or Authorized Person's Signature | Insured's or Authorized Person's Signature