Gate Healing, PLLC
Jonathan F. Anderson, LPC-Supervisor
Professional Consulting, Psychotherapy & Supervision
(512) 771-7621
3939 Bee Cave Rd, Ste A-203
Austin, Texas 78746

Client Intake

Name:_____ Email:_____

Address:_____City:_____Zip:_____

Home#:_____Cell#_____ Work#:_____

Marital Status:_____Date of Birth:_____

Employer:_____Occupation:_____

Reason for Consulting the GATE:_____
Referred By:_____
Can we contact and thank the referring provider? Y / N

Current Medications:_____

Have you been to a therapist in the past: Yes/ No
If so, when and for what reasons:_____

THERAPY AGREEMENT:
By signing this form, I understand and agree to the following:

A session lasts 45 minutes ($200); individual extended 90-minute sessions are available ($400). Full payment is expected at each session**.** Mr. Anderson does not accept any insurance but will provide receipts upon request. **For appointments not kept, canceled, or rescheduled within 48 hours of appointment *for any reason, you will be responsible for your full session fee***. This fee is **NOT** billable to an insurance company and **will** be charged to my credit card (below) if payment is not received. Phone consultations over 5 minutes are charged at the rate of $7.50 per minute for the full duration of the call. A fee of $35.00 is charged for returned checks. Fees apply for letters, case summary requests, and time spent in court or with your attorney ($500/hr. If I am subpoenaed or am asked to testify in court, I will have to cancel my entire day of clients due to the unpredictability of when cases come up on the docket, therefore, the minimum charge is for 6 hours, regardless of when the case is called). These fees will be charged to your credit card.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third-party payors and/or other health practitioners. I have read the Informed Consent for the office of Jonathan F. Anderson/Gate Healing, PLLC.

I agree to be responsible for payment of all services rendered on my behalf or for my dependents and/or fees for appointments not kept or canceled/rescheduled within 48 hours of the appointment time. I give Jonathan F. Anderson the right to seek the services of a bill-collecting agency in efforts to collect fees that I have not paid to him for services rendered and/or for canceled, missed appointments, or for late rescheduled appointments.

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An outstanding balance may be charged to my credit card. VISA MC AMEX Discover

Card Number: _____

Expiration Date: _____

Security Number (3 or 4 digits on the signature line on the back of the card): _____

Billing Zip Code: _____

Name on the Card:_____

X
_____
Signature of Card Holder Date

Mental Health Professionals regularly seek consultation with their colleagues to ensure the highest quality of therapy and treatment for the clients and prevent personal biases from hindering the therapeutic process. Despite the extra expense to the therapist for this consultation, it is essential to maintain the highest standards for your care. All legal and ethical confidentiality laws and standards apply during these professional consultations.

I give my permission for Jonathan F. Anderson, or one of his interns, to provide mental health services to me.

I understand that after the final session or if I have not attended a therapy session in three months, the client/therapist relationship will be considered closed unless I initiate further contact. I further understand that I can re-initiate therapy after my case is closed.

X
_____ _____
Signature of Client (& parent if the client is a minor) Date