Gate Healing, PLLC
Jonathan F. Anderson, LPC-Supervisor
Professional Consulting, Psychotherapy & Supervision
(512) 771-7621
3355 Bee Caves Rd, #505
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 ($150); individual extended 90-minute sessions available ($300); half session lasts 25 minutes ($80). Full payment is expected at each session**.** Session fees paid through insurance only require your co-pay/co-insurance, or insurance rate until deductible is met. **For appointments not kept, canceled, or rescheduled within 24 hours of appointment *for any reason, you will be responsible for your full session fee***. This fee is **NOT** billable to 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 $2.00 per minute for the full duration of the call. A fee of $30.00 is charged for returned checks. Fees apply for letters ($20 each), case summary requests ($50 each), and time spent in court or with your attorney ($250/hr). These fees will be charged to your credit card if not paid

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/The GATE.

I authorize and request my insurance company to pay directly to Jonathan F. Anderson benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. 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 cancelled/rescheduled within 24 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 my insurance company has not paid and that I have not paid to his for services rendered and/or for cancelled, missed appointments or for late rescheduled appointments.

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Outstanding balance may be charged to my credit card. VISA MC AMEX Debit: Credit:

Card Number:_____Expiration Date:_____

Security Number (last 3 digits on signature line on back of card):_____

Name on the Card:_____

_____
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 in the event that 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.

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

Insurance information (Value Options ONLY is accepted):

Insurance Co:_____ Ph# for Mental Health Ins:_____

Name of Insured:_____ Name of client:_____

Subscriber/ID#:_____Group#:_____

Client's ID# (if different from subscriber):_____

Address of insured/subscriber: _____

SSN of Insured:_____ DOB of insured:_____
Relationship to client:_____

Deductible:_____ How much of Deductible has been met?_____
Your Co-Pay/Co-insurance:$ /%_____ Pre-Authorization#:_____
How many sessions approved:_____ Date span of approval:_____
