Michael Lesher, M.Ed., LPC # 76178
michael@authentovative.com
832-900-9048
www.authentovative.com

CLIENT INFORMATION (*Please Print)*

Client's full name: _____

Preferred name: _____Date of Birth: : ____ / ____ / ____

Home Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Okay to leave message? Yes No
HM WK Cell Okay to text? Yes No

Email address: _____
(For scheduling appointments only.)

Sex: _____ Age: _____ Gender Identity: _____ Ethnicity: _____

School (if student): _____

Physician: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

Insured/Responsible Party Information

Insured's full name: _____ DofB: ____ / ____ / ____

Relationship to client: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Okay to leave message? Yes No
HM WK Cell Okay to text? Yes No

Employer: _____ Phone: _____

Insurance Co: _____ ID#: _____ Group #: _____

Billing and Insurance Policy:

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

When services are provided, it is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance company. There will be a $35 service charge on all returned checks.
In the event that your account goes to collections, there will be a $65 collection fee added to your balance.

Signature: _____ Date: ____ / ____ / ____

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INFORMED CONSENT

Thank you for choosing **Michael Lesher, LPC** at Authentovative Counseling Services, PLLC (ACS) for counseling services. This document is intended to inform you of our policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. ***Michael Lesher earned his Master of Education in Counseling at the University of St. Thomas and is licensed by the State of Texas as a Licensed Professional Counselor.*** Treatment practices, philosophy and plan limitations and risks will be discussed in our first session.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communications and clinical records are strictly confidential, except:

a. if you report abuse or neglect of a minor or elderly; then, by Texas state law, M. Lesher is obligated to report this to the appropriate law enforcement agency;
b. if you sign a release of information to have specific information shared with specific individuals or institutions;
c. if you provide information that informs M. Lesher that you are in danger of harming yourself or others;
d. information necessary for case supervision or consultation;
e. diagnosis and dates of service shared with your insurance company to process your claims;
f. or when otherwise required by law.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact emergency services (911) for those services. M. Lesher will follow those emergency services with standard counseling and support to the client or the client's family.

Name (please print): _____ Birthdate: _____

Signature: _____ Date: _____

Consent for Treatment of Minors:

I consent that Michael Lesher, LPC may treat _____ as a client and affirm that I have the right to give such consent.

Name (please print): _____ Relationship: _____

Signature: _____ Date: _____

Financial/Insurance Issues:

Payment is requested at the time that services are rendered. If a parent/guardian is paying for services, payment also may be sent any time before the appointment to the mailing address noted above or provided through the online client portal. I understand that insurance will not cover services provided by a practicum student or intern.

Negotiated rate: $125/session (initials) _____

If you need to cancel/reschedule an appointment, please give **24-hour advance notice**, otherwise you may be billed at the hourly rate.

(initials) _____

Appointment information is considered "Protected Health Information" under HIPPA. By my initials, I'm waiving my right to keep this information completely private and requesting that it be handled as I have noted in my online profile.

(initials) _____

You have the right to inspect and obtain a copy of your information contained in my records. Under limited circumstances, ACS may deny your request to inspect and copy. If you ask for a copy of any information, ACS may charge a reasonable fee for the costs of copying, mailing and supplies. If you feel that information contained in your record is incorrect or incomplete, you may ask your counselor to add information to amend the record. If your request is denied, you have a right to file a statement that you disagree. Your statement and the response of your counselor will be added to your record. ACS will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:
Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369
or call 1-800-942-5540 to request the appropriate form or obtain more information.