

Gisela Lin Counseling and Consultation Services, PLLC
1401 Sandia Plaza, Suite 1
Bryan, TX 77802
979-314-9698
DrLinCares@counselingmail.com
DrLinCares.com

Informed Consent for Treatment & Financial Responsibility Agreement

By signing the Informed Consent for Treatment and Financial Responsibility Agreement, I acknowledge I have read the Practice Policy of Gisela Lin Counseling and Consultation Services PLLC and Jun-chih Gisela Lin, Ph.D., ABPP.

I, _____, living at _____, give my consent to receive counseling services (in person or Telehealth) from Jun-chih Gisela Lin, Ph.D., ABPP. Dr. Lin is a board-certified counseling psychologist and a licensed psychologist in Texas. I have freely chosen to enter into counseling/therapy with Dr. Lin. I understand that I may discontinue counseling/therapy at any time. I have been given information about the advantages and disadvantages of the counseling recommended as well as other alternatives.

I understand that I need to keep all scheduled appointments, or advise Dr. Lin at least 48 hours in advance if I cannot keep an appointment. Except in the case of extreme emergency, I will pay \$90 for late cancellation, or \$180 for no show charge ____ (initial here). If I have multiple cancellations or no shows, I will discuss with Dr. Lin the challenges of keeping my appointments. Further, I understand that if I do not contact Dr. Lin to reschedule within 60 days of a late cancellation or missing appointment, the counseling relationship will be terminated. If I would like an appointment reminder, I may be reached by email _____ or be contacted at _____. Dr. Lin does not provide 24-hour crisis counseling. I understand that in case of crisis, if I cannot reach Dr. Lin at 979-314-9698, I can call my local MHMR number, or call 988 Suicide and Crisis Lifeline, or call the National Suicide Prevention Lifeline 1-800-273-TALK (8255). If I have a life-threatening emergency, I should call 911, or go to the nearest hospital emergency room.

Confidentiality and Privacy:

State law and ethical codes protect my right of privacy and confidentiality regarding psychological services. I have been given an opportunity to discuss any questions about the HIPPA notice with Dr. Lin. I have been given information regarding the limits of confidentiality. I understand that in most cases, no information concerning me will be released without my signed permission within the limits of confidentiality, except when required by state law (e.g., imminent danger to self or others; child/elder abuse) or when ordered by a judge. _____ (initial here)

Payment:

Private Pay: I have been given information regarding the cost of services from Dr. Lin. I agree to pay at the time of each visit a charge of \$250 for the initial non-crisis session, \$180 per hour for other scheduled sessions, \$250 per hour for crisis appointments.

Managed Care: My office visit co-pay is \$ _____ (please verify with your insurance network). Full payment of the co-pay is due at each session. Pre-certification or pre-determination of insurance coverage is my responsibility. Furthermore, should there be a balance due after payment by the insurance company, I agree to remit the balance upon receipt of the billing statement, or be charged with credit card on file.

Late Cancellation or No Show: Except in the case of extreme emergency, I will pay \$90 for late cancellation, or \$180 for no show charge. Credit cards, cash or checks are accepted. _____ (initial here).

Please enter credit card information below. Name _____, credit card number _____, expiration date _____, security code _____, zip code of the credit card _____

Dr. Lin also uses Ivy Pay for therapist, a HIPPA compliant service that you can put your credit card, debit card, HSA, FSA on file to pay. Please list the phone number _____ so Dr. Lin can text your payment information through Ivy Pay. You can choose to receive a good faith estimate or receipt with service information through Ivy Pay upon request.

Agreement:

I understand, acknowledge and accept the outlined terms. Further, if release of any information is required to process insurance claims for benefits to be paid directly to Gisela Lin Counseling and Consultation Services PLLC or Dr. Lin, I authorize her to provide any information necessary. By giving my information, I give Dr. Lin permission to email or call me, bill my insurance company, or charge the credit cards I provided for services, late cancellation or missing appointments when applicable.

Name of Client/Guardian

Signature of Client/Guardian

Date

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Authorization to release medical information/assignment of benefits

Subscriber Name	Date of Birth	Sex/Gender/Pronoun	Address	Phone	
		Marital Status			
Name of Primary Insured if different	Date of Birth	Relationship to you	Address	Phone	
Insurance Name	Identification Number		Group Number	Network Number	Coverage Date

Authorization to release medical information/assignment of benefits:

I hereby authorize Gisela Lin Counseling and Consultation Services PLLC and Jun-chih Gisela Lin, Ph.D., ABPP to furnish appropriate and necessary details of medical information to my insurance company.

I hereby authorize payment of medical benefits to Gisela Lin Counseling and Consultation Services PLLC or Jun-chih Gisela Lin, Ph.D., ABPP for psychological services rendered.

I will provide Dr. Lin a copy of the Insurance card and Driver’s license or a State issued ID.

Client Signature _____ Date _____

Parent or Guardian _____ Date _____

(if client is a minor)

Please provide emergency contact

Name: _____, Relationship to you _____, Phone _____