MOBILE COUNSELING, PLLC

RECORDS REQUEST (update January 2021)

Date of Request: ________________ Dates of Service: ________________ to ________________

Clients Name: ____ DOB: __________________

Name of Person Requesting Records: ____
Relationship to client (if not the client): ____

Address and Phone Number of Person Requesting Records: ______________________________
____

If the child no longer resides with **both biological parents due to separation, divorce, or change in guardianship, legal paperwork regarding custody and guardianship information related to who is able to seek medical/psychological services and who may obtain records must be provided prior to the release of any records. It is the policy of Mobile Counseling, PLLC to give all persons with legal rights the same opportunities.*

By signing this authorization, I hereby request MOBILE COUNSELING, PLLC, 1412 Main Street, Suite 613, Dallas, TX 75202 to release my/or my child's protected health records, including confidential counseling records to the following person(s) at the address listed below for the purposes described:

Records to be mailed to: ____
Address: ____
____

Phone Number: ____________________________

The purpose of this request: ____

CLIENT and legal representative MUST read and initial the following statements:

- I understand that by requesting this record the information disclosed by this request may no longer be protected by federal privacy regulations or other applicable state and federal laws.

  Client: ______________________ Parent/Guardian: ______________________

Client Signature: ___________________________ Printed Name: ______________________ Date: ________

Guardian Signature: ___________________________ Printed Name: ______________________ Date: ________

Please return this signed request along with a copy of your ID, any necessary guardianship documents, and the completed credit card authorization (below) for the listed fee to:

Mobile Counseling, PLLC
1412 Main Street, Suite 613
Dallas, TX 75202

***All complete requests for records will be mailed within 14 business days of receipt of complete request.**

MOBILE COUNSELING, PLLC

OFFICE POLICY (update January 2021)

FEES FOR SERVICES OTHER THAN THERAPY

1. Report Preparation: If report preparation is requested or required for supplemental services, the time rate charged for this service is $200.00 per hour (minimum 1 hour charged).
2. Review of Provided Documents: Documents related to history, background information, school behavior, or testing are billed at the rate of $2.00 per minute if it is outside the therapy session.
3. Copies: Copies of records are billed at $30 for up to 50 pages (additional pages are $1/each).
4. Phone Calls: All calls that are therapeutic in nature (i.e., client discussing their problems) or for supplemental services (i.e., psychiatrist or attorney consultations, etc.) are billed at $2.00 per minute. Calls related to scheduling appointments are not billed.
   NOTE: Report Preparation, Review of Provided Documents, Copies, and Phone Calls are not reimbursable by insurance. The client is solely responsible for these fees. These services will be charged to your credit card on file the date of service unless you have made other arrangements for payment.
5. Professional Fees: Court appearances, depositions, and attorney consultations are $200.00 per hour (including all time involved in preparation, research, travel time to and from the attorney office or court house, in addition to all other expenses incurred in relation to testifying like parking fees, mileage, etc.). A fee of $1,000.00 is to be paid in advance of the court date, deposition, or attorney consultation, and this fee is not refundable. If the costs for the court testifying process/deposition exceed the $1,000.00 then the additional fees will be immediately billed to your credit card on file, or are due upon receipt of the invoice. All LPC-Interns will be accompanied by their LPC-Supervisor.
   The party issuing the subpoena is responsible for the professional fees.
   NOTE: Even though you are responsible for the professional fee, it does not mean that testimony will be solely in your favor. Only the facts of the case and professional opinion of your counselor can be testified.
6. Returned checks: There is a $30.00 charge on all returned checks.

TYPE OF CARD ❑ AMEX ❑VISA ❑ MC ❑ DISCOVER

ACCOUNT # ______________________________________ EXP. DATE _____________

THREE DIGIT CID NUMBER (4 DIGIT FOR AMEX) _______________

CARDHOLDER'S NAME ____

BILLING ADDRESS ____

____

I agree to the above terms and authorize Mobile Counseling, PLLC to charge any payment for professional services or outstanding balances including return check fees to the above credit card.

____ __________________

SIGNATURE DATE