Christy A. Cole, LCPC
Counseling and Psychotherapy for Wellness

CLIENT REGISTRATION

Date: __________ **Client Name**: ____
First Middle Last

Gender: ________ **Date of Birth**: __________________________

Guardian/Parent Name(s): __________________________ **Social Security Number**: _________________
(If client is a minor)
____

Address: ____ **Phone**: ________________________________

____ **OK to leave message?** Yes No

E-Mail: ____ **OK to contact by e-mail?** Yes No

Emergency Contact: ________________________________ **Phone**: _________________________________

Primary Care Physician: _____________________________ **OK to inform doctor of treatment?** Yes No

Insurance Company: _________________________________ **Subscriber ID Number**: __________________

Group Number: _____________________________________ **Plan Name**: ____________________________

Name of Primary Person Insured: _______________________ **Date of Birth**: __________________________

Address of Primary Person Insured: ____

Supplemental Insurance Information and Number: ____

How did you hear about my practice? ____

____ **Please add me to the mailing list so that I can be informed of upcoming events, groups, workshops, news, etc.**

____ ____________________
Client/Guardian Signature **Date**

____
(Last Name, First Name)

Christy A. Cole, LCPC
Counseling and Psychotherapy for Wellness

2 Christensen Lane, Ste. #2, Kennebunk, ME 04043 (207) 370-5272 christy@christycolecounseling.com
MA Clinical Mental Health Counseling 5/20/2002 Lesley University Maine LCPC #: CC2671 issued 12/01/2004 expires 11/30/2022
Business Hours: Tuesday, Thursday 8:30 – 6:00; or by Appointment

CONSENT TO TREATMENT

This document indicates that I have read and understand the Statement of Practice and Policies and I am seeking and consenting to treatment by Christy A. Cole, LCPC under the terms described. I understand that Christy A. Cole, LCPC is trained and licensed to provide psychotherapy services to children and adults in an individual, couples, family or group therapy format. I authorize her or an intern under her supervision, to conduct an assessment and/or to administer such treatment as indicated by her education, training, and experience in psychological intervention and the current standard of practice. Treatment will involve an ongoing process of diagnosis, treatment planning, and defining short and long-term goals. I understand I have the right to refuse any treatment procedure and that I have the right to withdraw from treatment at any time. Christy A. Cole, LCPC, retains the right to end treatment for any reason, including nonpayment. I understand that no promises have been made to me as to the results of treatment provided by this therapist.

STATEMENT OF PRACTICE AND POLICIES

Please initial the following statements acknowledging that you have read, understand, and agree to the conditions and boundaries of our work together:

_______I give permission to be contacted by phone, email, or in writing if my therapist needs to reach me. The therapist may leave a message at the phone number provided. I understand that scheduling issues are best conducted via email. At the client's request, an encrypted email service can be set up and utilized for this purpose. It is important to understand that if you communicate confidential or private information via unencrypted e-mails, texts, e-fax, phone messages or video conferencing, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted and I will honor your decision to communicate in this manner.

_______I understand that sessions last for 53 minutes and a fee of $140 per session is due at the time of service, (unless insurance is being utilized or other arrangements have been made), and can be paid by cash, personal check, or credit card. I understand that an intake assessment and report will be completed at the start of services and on a yearly basis for a fee of $210. I understand that Christy A. Cole, LCPC has a limited number of sessions available for a sliding fee based upon financial need. I understand that if an account balance is outstanding after 90 days it will be submitted to our collection agency and that I will be responsible for any reasonable collection costs and will be charged $140 in addition to the outstanding balance due. If the client intends to utilize health insurance benefits please see the attached addendum.

_______I understand that any time spent by Christy A. Cole, LCPC pertaining to my treatment that I request outside of my scheduled appointment time will be billed at a rate of $35 per 15-minute increment. I understand that most of these services are not covered by insurance and that I will be solely responsible for paying for these services out of pocket. Examples of billable time include but are not limited to phone or video consultations outside of treatment time; lengthy email or text correspondence; collaborating with family members, doctors or other professionals via phone or in person; writing clinical letters, reports, summaries or other documentation at your request; travel and time spent in meetings pertaining to the client, etc. When requesting services rendered off-site, I understand that I am additionally responsible for paying mileage at the standard rate.

_______Due to the nature of the therapeutic process, it is agreed that should there be legal proceedings, (including but not limited to divorce and custody disputes, injuries, lawsuits, criminal matters), neither you (the client(s)) nor your attorney(s), nor anyone acting on your behalf will call on Christy A. Cole, LCPC to testify in court or at any other proceedings.

_______I understand that my appointment is reserved time. I also understand that my insurance company will not reimburse for missed appointments. Should I not provide 24-hour notice for cancellation (except for illness or emergencies), I am solely responsible for the full fee of $140. I also understand that if I am more than 15 minutes late I run the risk of forfeiting my appointment entirely. I understand that missing two appointments in a row may forfeit my space on the caseload.

_______I understand that for psychiatric emergencies, I may go to my local emergency room or call Crisis Response Services at **1-888-568-1112**. I understand that Christy A. Cole, LCPC, will be available to me at her earliest convenience, but may be unreachable because of the confines of a solo practice. ***For extreme life-threatening emergencies, I will go to the emergency room or call 911.***

_______I understand that a psychiatric evaluation may be recommended. If I choose not to follow through with this recommendation, I relinquish any liability to Christy A. Cole, LCPC. I further understand that continued treatment may be contingent upon my following through on this recommendation.

_______I agree to report any dissatisfaction with the work or therapeutic process to Christy A. Cole, LCPC. I agree that if I want to terminate treatment, I will schedule and attend a last session to finalize the work.

____
(Last Name, First Name)

Christy A. Cole, LCPC
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ISSUES OF CONFIDENTIALITY

I understand that I have the right to the confidentiality of my records. I further understand that there are **exceptions to confidentiality**. I understand that Christy A. Cole, LCPC, may:

_______be mandated by law to report cases of psychological, sexual, or physical mistreatment of minors, elders, and others unable to care for themselves.
_______be mandated by law to report clear and immediate danger to myself or other(s).
_______be a defendant in a civil, criminal, or disciplinary action arising from the therapy in which my confidentiality may be disclosed in the course of that action.
_______share information as needed in the event of a medical emergency.
_______be authorized by me to release information to a referral source, primary therapist, primary care physician, or any other person for consultation or for coordination of services by my signing a Release of Information form.
_______be required to break confidentiality due to court order.
_______inadvertently compromise my privacy when diagnostic codes are released to insurance companies and billing agent for billing purposes.
_______participate in individual or consultation groups attended by other professionals and that aspects of our work may be discussed for learning purposes and that my name will never be disclosed.

I understand that my signature to this document indicates my agreement to the procedures above. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it.

Client Signature **Date** **Guardian Signature (as appropriate)** **Date**

Copy wanted: **YES** **NO** (circle one) **Date Given**: ________________

I have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses lead me to believe that this person is fully competent to give informed and willing consent.

Provider Signature **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that on ___________ I reviewed the Notice of Privacy Practices from Christy A. Cole, LCPC, which sets forth the ways in which my personal health information may be used or disclosed by Christy A. Cole, LCPC, and outlines my rights with respect to such information.

Client/Guardian Signature **Date**

RECEIPT OF CLIENT BILL OF RIGHTS

I hereby acknowledge that on __________ I received the Client Bill of Rights from Christy A. Cole, LCPC, which sets forth the rights I have as a counseling client in the state of Maine.

Client/Guardian Signature **Date**

____
(Last Name, First Name)

Christy A. Cole, LCPC
Counseling and Psychotherapy for Wellness

TELE-COUNSELING INFORMED CONSENT

Tele-counseling or teletherapy is the delivery of counseling or therapy services using interactive video conferencing. Tele-counseling enables a therapy provider at a distant location to provide consultation, assessment, and treatment to me. I understand that this consultation will not be the same as direct client/therapist visit. Tele-counseling will allow me to receive outpatient therapy without the need to visit the office and travel long distances.

During the tele-counseling consultation:

- Details of my mental health history, medical history, and current psychological symptoms will be discussed.
- I will be informed about who is present in the office.

Expected Benefits:

- Improved access to outpatient therapy by enabling a client to remain in his/her home, their primary care provider's office, or another private location.
- More efficient mental health evaluation and management.
- Obtaining the expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of tele-counseling. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images, poor audio) to allow for appropriate decision making or treatment by the mental health provider.
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete mental health records may result in adverse treatment reactions or judgment errors.

Alternatives to the use of tele-counseling:

- Traditional face to face sessions in our office when available.

My Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to tele-counseling.
- I have the right to withhold or withdraw my consent to the use of tele-counseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that Christy A. Cole, LCPC has the right to withhold or withdraw consent for the use of tele-counseling during the course of my care at any time.
- I understand that all rules and regulations which apply to the practice of therapy/counseling in the state of Maine also apply to tele-counseling.

My Responsibilities:

- I will not record any tele-counseling sessions without written consent from Christy A. Cole, LCPC. I understand that Christy A. Cole, LCPC will not record any of our tele-counseling sessions without my written consent.
- I will inform Christy A. Cole, LCPC if any other person can hear or see any part of our session before the session begins. Christy A. Cole, LCPC will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Christy A. Cole, LCPC am responsible for the configuration of any electronic equipment used on my computer for tele-counseling. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that I must be physically present in the state of Maine to be eligible for tele-counseling services from Christy A. Cole, LCPC. Please note: additional states may temporarily be covered during the pandemic.
- I understand that during my initial evaluation by Christy A. Cole, LCPC, I will be required to provide photo identification to verify my identity to my provider's satisfaction before the evaluation.
- I understand that payment will be made by credit card through IVY Pay.

Client consent for the use of Tele-counseling:

I____have read and understand the information provided above regarding tele-counseling and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-counseling in my mental health care and authorize Christy A. Cole, LCPC, to use tele-counseling in the course of my diagnosis and treatment.

____
Client/Guardian Signature **Date**

____

(Last Name, First Name)

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CREDIT CARD AUTHORIZATION

We require you to provide your credit/debit card information on file with us through IVY PAY (https://www.talktoivy.com/ivypay), which is a credit card payment system designed specifically for Psychotherapists and their Clients. Ivy Pay automatically charges for any co-pays, co-insurance, deductible amounts, payments for tele-counseling, in person counseling, and professional service charges such as late cancelation or missed appointment charges when necessary.

IVY Pay works with your debit card, credit card, HSA or FSA account. It is HIPAA secure and it keeps our therapeutic relationship confidential. I will not keep your credit card on file, (it will be on file and securely maintained through IVY PAY), so that you can easily pay for any sessions attended, remote, or missed without any hassle. It is the client responsibility to keep cards accurate and up to date.

Here's how it works:

Your therapist will send you an invite text via IVY Pay's secure system - this text will come from our system's phone number:
Tap on the link in your invite text to be taken to the secure 'Add Card' form.
Scroll down on the 'Add Card' form, add your card details, and tap 'Save & Pay'. Your card will be encrypted and stored on Ivy Pay's secure servers, and will be charged for that day's session

Payment is required at the time of service. Your therapist will bill your credit card automatically for the agreed upon payment amount after services are rendered.

Your signature below indicates that you have read and understood our credit/debit card and delinquent account policy. You are authorizing Christy A. Cole, LCPC to charge your Ivy Pay credit card for all services rendered and/or late cancellation or no-show fees. You are aware that your information will be saved on file for future transactions on your account.

____

Client/Guardian Signature **Date**

____

Phone Number to receive texts from IVY Pay

____
(Last Name, First Name)

Christy A. Cole, LCPC
Counseling and Psychotherapy for Wellness

HEALTH INSURANCE ADDENDUM

*****Patients Are Responsible for Understanding Their Own Insurance Policies*****

_______I understand that Christy A. Cole, LCPC accepts some major insurance plans and that if I intend to use my insurance it is my sole responsibility to ensure that services will be covered prior to beginning treatment.

_______I understand that my failure to verify benefits will render me liable to pay the full fee out of pocket should insurance claims be denied.

_______I understand that I must provide Christy A. Cole, LCPC with my insurance information and authorization number prior to beginning treatment. I also understand that I must provide all identifying information required by insurance to reimburse.

_______I understand that I am responsible for the copayment or coinsurance set by my insurance and that this is due at the time that services are rendered. I understand that should I have a deductible to meet, I am responsible to pay for services within 30 days of the first billing statement.

_______I understand that I am solely responsible for ensuring that proper procedures, (including but not limited to preapproval, session limits, ensuring timely submission of required outpatient treatment reports), are followed for services to be covered and that I am responsible to pay for the services out of pocket should they be denied for these reasons.

_______I understand that utilizing insurance benefits requires that I be given a diagnosis at the onset of treatment and that Christy A. Cole, LCPC disclose confidential and protected health information to prove medical necessity with each claim submission and at the request of the insurance company. Only the minimum necessary information will be communicated to the insurance company. I understand that Christy A. Cole, LCPC has no control over what information will be requested or knowledge about what insurance companies do with the information submitted.

_______If my insurance refuses to cover any services I receive, I understand that I am responsible to pay for the services out of pocket at the rate contracted by my insurance plan. If I wish to submit an appeal for services that are limited or denied I understand that it is my responsibility to contact my insurance company to initiate this process.

_______I agree to inform Christy A. Cole, LCPC immediately of any changes to my insurance policy.

____

Client/Guardian Signature **Date**

AUTHORIZATION TO BILL HEALTH INSURANCE/ASSIGNMENT OF BENEFITS

I _________________________ (print name) do hereby give full permission and authorize Christy A. Cole, LCPC, to bill _________________________ (name of insurance company) for services rendered by Christy A. Cole, LCPC. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to: Christy A. Cole, LCPC; 2 Christensen Ln., Ste. 2, Kennebunk, ME 04043.

____

Client/Guardian Signature **Date**

____

Provider Signature **Date**

____
(Last Name, First Name)

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CLIENT BILL OF RIGHTS

Clients of Christy A. Cole, LCPC have the right:

- To expect that a counselor has met the licensure or registration requirements of state law and rule.
- To examine a counselor's licensing credentials.
- To obtain a copy of the Code of Ethics of the Board of Counseling Professionals Licensure.
- To file a complaint against a counselor with the board.
- To be informed of the cost of professional services before receiving services.
- To expect complete confidentiality except as required by law. and
- To refuse any recommended services and to be advised of the consequences of this action.

The practice of counseling is regulated by the Board of Counseling Professionals Licensure. The board is authorized by law to discipline counselors who violate the board's law or rules. To learn about the complaint process, or to file a complaint against a counselor, contact: Complaint Coordinator Office of Licensing and Registration; 35 State House Station; Augusta, ME 04333 Tel: (207) 624-8660