Take your life to the next level

Heidi Kiebler-Brogan, M.A., LPC, NCC

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Patient Update Form-2020

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician: **Allergies**	**Psychiatrist (if any):** **Medications**
Contact Number:	**Contact Number:**

Please include dates, locations, frequency and reason

Recent Hospitalizations:_____

_____

_____

Legal Issues:_____

_____

_____

Self-Harm: including cutting, self-mutilation, suicidal thoughts, suicidal attempts:_____

_____

_____

_____

Addictions/Abuse of drugs, alcohol, gambling:_____

_____

_____

School or work disciplinary actions:_____

_____

_____

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

Fees for Professional Services:

I (we) agree to pay ***Heidi Kiebler-Brogan/IE Counseling*** at the time services are provided, a rate of:

$275 per hour for initial consult and assessment (or prorated calculations of this, depending on the length of meeting)
$250 per hour, for one (1) hour individual sessions (or prorated calculations of this, depending on the length of meeting)
$200 per 45 mins individual sessions (or prorated calculations of this, depending on the length of meeting)
$275 per hour for family and/or couples' sessions (or prorated calculations of this, depending on the length of meeting)

Other services (attendance at outside meetings, phone sessions, documentation and travel time for example) will be calculated in the same manner based upon individual, family or couples work.
Sessions are payable by check, cash, credit card, PayPal…. at time of service.

*In accordance with State and Federal law all credit card payments will include a 2.9% plus $0.30 per transaction fee.
The full fee of a scheduled appointment is charged for missed appointments or cancellations with less than 24 hours' notice.

Returned checks will be charged at $35.00 per incident.
Late payments will accrue 20% interest charge per month delinquent.

Part Two Release of Information Authorization to Third Party

Heidi Kiebler-Brogan, MA, LPC, NCC will not provide any information to third parties without your written consent which will serve as authorization. Insurance information will be provided to insurance providers by you, the client, at your discretion. You may choose to submit your invoice for reimbursement to your insurance provider as your invoice is your property.

Part Three Legal Procedures

Under no circumstances will **IE Counseling,** or its representative, **Heidi Kiebler-Brogan, MA, LPC, NCC,** testify on behalf of, or against, any party covered under this agreement. The client(s) hereby waive any right to have Heidi Kiebler-Brogan, MA, LPC, NCC testify in any Court of Law. The client(s) agree that he/she/they will not subpoena Heidi Kiebler-Brogan, MA, LPC, NCC to court. None of the work product of this process will be used for litigation.

Part Four Acknowledgement and Acceptance of Agreement

Heidi Kiebler-Brogan, MA, LPC, NCC and the client(s) acknowledge that they have read this agreement, understand all of the terms and conditions and agree to abide by them. The

parties understand that by agreeing to participate in services they are accepting and agreeing to all above terms of provision

_____ _____
Print Name of Patient or Guardian (if under 18 years of age)
Signature of Patient or Guardian (if under 18 years of age)

_____ _____
Print Full Name of Patient or Guardian (if 16 years or older)
Signature of Patient (if 16 years or older)

Date:_____

_____
Heidi Kiebler-Brogan, MA, LPC, NCC
Licensed Professional Counselor

Date_____

I have read and fully understand and accept the following policy and procedures available for download on the website www.iecounseling.com:

1. **Limits of Confidentiality _____ (initial)**
2. **Consent to Treat a Minor_____(initial)**
3. **Professional Practices_____(initial)**
4. **Venmo/PayPal Billing Consent_____(initial)**
5. **Payment Contract 2020_____(initial)**
6. **HIPPA Privacy Notice 2020_____(initials)**

_____ _____
Print Name of Patient or Guardian (if under 18 years of age)
Signature of Patient or Guardian (if under 18 years of age)

_____ _____
Print Full Name of Patient or Guardian (if 16 years or older)
Signature of Patient (if 16 years or older)

Date:_____