WELCOME TO YOUR THERAPY EXPERIENCE. I am pleased to have the opportunity to work with you and I hope this handout will provide helpful information regarding services. Please feel free to ask questions at any time. Counseling Concepts provides administrative support, including billing to your provider. The therapists who share this office are all sole proprietors and although they share a commitment to mental health services, they are not a group or partnership. You will pay your provider directly for services. Do **not** make checks out to Counseling Concepts.

APPOINTMENTS: Services are by appointment only. The length of the appointment varies on the basis of the service provided and the time allowed by your insurance company. Individual and family therapy is generally scheduled for 45-minutes. Please remember it is important to cancel any appointment 24 hours in advance. This allows time to offer the time to other clients that may be waiting. **You will be charged a $50.00 fee for a missed appointment. Two missed appointments are grounds for termination of professional services. Please initial._____**

CONFIDENTIALITY: All therapeutic communication, records, contacts with professionals and support staff will be held in strict confidence. Information may be released in accordance with state and federal law, only when: 1) the client signs a written release of information indicating informed consent to such release; 2) the client elects to use insurance, managed care organizations, or other third party payers; 3) the client expresses serious intent to harm himself/herself or someone else; 4) there is evidence or reasonable suspicion of abuse of a minor child, elder person 65 years or older or dependent adult; or 5) there is a court order. It is my policy to consult with the client prior to such disclosures.

CHARGES: The charges for counseling services are based on the usual and customary fee in this area. The fee for an initial assessment is $150.00 per clinical hour (45-minute sessions). The fee per session is $140.00 per clinical hour (45- minutes sessions). This fee includes my time on your behalf, including record keeping and preparations. Fees are due at the time of service, unless prior arrangements are made. If a report is requested of an assessment, other than to a third party payer, payment in full is necessary prior to the release of any findings. Should you request your therapist's appearance in court, a fee of $250.00 per hour will be charged and must be paid prior to the court date. Please be sure to discuss ahead of any subpoena, your desire for the therapist's appearance in court and the complicated nature of the request.

INSURANCE: If you have an insurance plan, your insurance company may reimburse your session fee. **Please note that you are responsible for all fees not reimbursed by your insurance company. It is your responsibility to keep this office aware of all changes in insurance plans.**

Please do not hesitate to discuss any of the policies with me. Again, Welcome.

# CLIENT INFORMATION SHEET

Client Name_____ M/F Marital Status S M D W
Address_____City_____State____ Zip____
Home Phone_____Work Phone_____ Cell Phone_____
Birthdate_____Age_____Social Security Number_____
Occupation_____Employer_____
Primary Care Physician_____
Client/Parent/Guardian email address_____
CLIENT Current Medications:_____
Names and ages of people living in your household:_____

Reminder THERE IS A $50.00 CHARGE FOR NO SHOW OR LATE CANCEL

## Insurance Information

Insurance Co_____
ID#_____Group#_____
Subscriber Name:_____SSN_____
Date of Birth_____Employer_____

## Please fill out if CHILD IS A MINOR

Mother Name_____Address_____
City_____State____Zip_____Daytime Phone_____
Occupation_____Employer_____
Father Name_____Address_____
City_____State____Zip_____Daytime Phone_____
Occupation_/Employer_____

## Emergency Contact:

In the event of an emergency, I consent for Counseling Concepts therapists and staff to contact: Name and relationship to client_____
Contact number _____ Signature and date _____

## Consent to treat a minor

I give consent to _____to provide services for my child for whom I am responsible.
Parent Signature_____Date_____

## Assignment of Benefits

I hereby authorize the provider of services to receive direct payment from my insurance company for the services rendered. I understand that I am financially responsible for any required copayments, deductibles or services not covered by my insurer. I agree to provide any information required to file my insurance claims. I authorize the release of any information acquired in the course of treatment for the purpose of insurance claim Filing. A photocopy of this authorization shall be considered as effective as the original.

Signature_____Date_____

I hereby acknowledge that I have received or been given an opportunity to read a copy of Notice of Privacy Practices. If I have any questions I will contact my therapist.

Signature_____Date_____

____Client refused to acknowledge receipt.
____I read and understand the policies of my therapist