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.

<u>INSURANCE</u>: 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

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services rendered. I understand that I am financially responsible for any required copayments, deductions of 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.	services rendered. I understand services not covered by my insur-	that I am financially re er. I agree to provide a rmation acquired in the	esponsible t any informa e course of t	or any required tion requireat f reatment f ective as the	red to file my for the purpose he original.	insurai	nce claims. I	
Signature Date I hereby acknowledge that I have received or been given an opportunity to read a copy of Notice of Privacy						Vation	of Privace	
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Client refused to acknowledge receipt.	Client refused to ac	knowledge receip	t.			11914	4	
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