Andrew W. Scott, M.Ed., LPC, LADC

1616 E. 19th Street, Suite 305
Edmond, OK 73013

Name:_____ Date: _____
First MI Last Maiden

DOB:_____ MALE FEMALE Age:_____ Race:_____

Home Address:_____
Street City/State Zip

Phone #: _____ Email:_____

Emergency Contact:_____ Emergency Phone Number:_____

Parent/Guardian Name: _____ Phone:_____

Referral Source: Internet Doctor Friend Church Other:_____

Please read the following information carefully. Your signature acknowledges that you have read, that you understand the contents, and, if applicable, consent to release of information for your insurance. If you have any questions regarding this form, please ask Andrew.

Consent: My signature below indicates my consent for myself and/or my minor child to enter and participate in voluntary counseling services with **Andrew W. Scott, M.Ed., LPC, LADC** under the provisions of the Oklahoma Mental Health Law. Any person under eighteen (18) years of age must be admitted with the consent of parent/legal guardian. As required by Oklahoma Statutes, section 51 title 43A, by signing below, I am certifying that I am not/my minor child is not in confinement on any criminal charge and the consumer has no criminal charges pending against same. I am also certifying that I have the legal authority to make custodial decisions concerning the minor listed below. Pursuant to OAC 86: 10-3-2(i), Andrew W. Scott, M.Ed, LPC, LADC does **not** provide forensic services, only professional counseling services. Andrew is currently licensed by the Oklahoma State Board of Behavioral Health Licensure as a **Licensed Professional Counselor** (**#3411**) and the Oklahoma State Board of Licensed Alcohol and Drug Counselors as a **Licensed Alcohol Drug Counselor** (**#831**).

Appointments: Andrew utilizes cognitive behavioral, reality theory, person centered, and eclectic approaches to the counseling services he provides. Services are by appointment only. The length of the sessions will be determined by the type of services and coordinated with mutual agreement between you and Andrew. Appointments are made at your request and on the assumption that you are going to attend and participate. If repetitive no show and cancellations occur this may be ground for termination of services and referral to other services as appropriate.

Fees: Services are rendered at $31.25 per 15 minutes. Most sessions last for 55-60 minutes, which would incur a $125 charge. The initial session is $150 and is for 55-60 minutes. Charges will occur for phone calls regarding treatment issues and incur a $31.25 charge for each 15 minutes. NO SHOW or CANCELLATIONS not made prior to 24-hours before the scheduled session will be charged full amount of the time that it was scheduled. All accounts with outstanding balance for ninety days will be charged a $10 administrative fee each month thereafter. There will be a $25 charge for checks returned for insufficient funds and checks will no longer be accepted in the future. Should this occur compensation should be arranged utilizing another form of payment prior to the next service. Visa, MasterCard, and Discover are accepted. If a returned check and the fee have not been paid within thirty days after the service provided a referral will be made to the District Attorney's office.

Payment: Payment is due at the time services are rendered, unless other arrangements have been made. Payment arrangements must be confirmed at the first session. Payment in full must be made at the time of the service except for services provided for an **in-network** insurance company. For those insurance companies that consider Andrew an **out of network** provider, reimbursement for services will be made to you by your insurance after the claim has been filed by Andrew. Very few policies cover 100% of the costs, so please contact your insurance company to understand the benefits allowed. Insurance will not and cannot be filed for missed or late cancelled appointments or any phone calls. You will be responsible for payment of these charges prior to the next service provided. My signature below indicates my consent for Andrew W. Scott, M.Ed., LPC, LADC to file claims and, if applicable, accept payment from my insurance company. My signature below also indicates that I understand the above payment policy.

_____ _____
(Client's Printed Name) (Parent/Guardians Printed Name)

_____ _____ _____ _____
(Client's signature) (Date) (Parent/guardian signature) (Date)

Revised 12/5/22

Confidentiality: All conversations and documentation will be kept confidential. I acknowledge and understand that should information need to be released, a release of information will be signed in accordance with 42 CFR Part 2 and 45 CFR Part 160 & 164. Exceptions to confidentiality exist in cases of imminent danger to self or others, child abuse or neglect, in which Andrew must contact the appropriate authorities.

Release of Information to file insurance:

I, _____ authorize: **Andrew Scott, M.Ed., LPC, LADC, 1616 E. 19th Street, Suite 305, Edmond, OK 73013, (405) 285-8226** to receive from/release to:

_____

_____

The following information: Demographic Information Diagnostic Code(s) Treatment Plans
Dates of Service Any Records Which May Contain Information About Substance Abuse
Other:_____

For the following purpose(s) of: **Billing/Claims for services provided**

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically from one year of date signed or on the specific event/condition:_____

Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing to the attention of: Andrew Scott, M.Ed, LPC, LADC, 1616 E. 19th Street, Suite 305, Edmond, OK 73013.

I understand that Andrew Scott, M.Ed., LPC, LADC is seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

My signature below acknowledges I have read and understand the above polices and that I have received a copy of the Notice of Privacy Practices of Andrew W. Scott, LPC, PLLC effective September 19, 2013 and Good Faith Estimate Notice.

I wish to have a copy of any documents received/signed on this date: ☐ **YES** ☐ **NO**
If you email or mail a copy back to Andrew, please keep a copy for your records.

_____ _____
(Client's Printed Name) (Parent/Guardians Printed Name)

_____ _____ _____ _____
(Client's signature) (Date) (Parent/guardian signature) (Date)