

Center for Child and Family Counseling, PLLC

Hello.

It is with great pleasure that we welcome you to our clinical practice. Our hope is to serve you and/or your family to work toward the best possible outcome.

You have several rights as a client. These include the right to know fees, ask questions and to end services at any time. The paper work which follows will also inform you of the limits of confidentiality and how your personal health information may be used with insurance companies.

The following paperwork must be completed in its entirety for the assessment and following counseling sessions to take place. Your information is confidential within the limits described on the following pages. Keeping your privacy is something we take very seriously. If you need assistance completing some of the questions, we will gladly assist you at our first session.

Please have a seat in the waiting area. Although we are expecting you, we may be with another client and will be with you as soon as possible.

Again, thank you kindly for choosing our practice. We look forward to providing counseling services to help you. .

If you are interested in counseling, please read and complete the information in this packet.

1. Client and Intake information.
2. Notice of Privacy Practices Handout is available.
3. Please note that if more space is needed turn page over and continue there.

This Information is required before services are provided.

Client and Intake Information

Full Name _____ SS# _____ DOB _____

Address _____ City _____ Zip _____

Home Phone Number _____ Cell _____ Work _____

Is it OK to leave a message at the numbers listed? YES NO

Emergency Contact _____ Emergency number _____

Parents Name, if a Child/ Adolescent _____

Insurance Subscriber (individual whose insurance is providing the coverage)

Subscriber's DOB _____ Subscriber's ID# _____

Effective Date _____ Subscribers Group Number _____

Subscribers Employer _____ Insurance Company Name _____

(Your mental health benefits may be administered by a different company than your card reflects)

Insurance Claims address:

_____ City State Zip

You agree to allow me to file/process for payment through your insurance on your behalf? YES NO

Is this an EAP referral/visit? YES NO Authorization # _____

Have you been preauthorized for this visit? YES NO Is Preauthorization required? YES NO

*****It is your responsibility to contact your insurance company for authorization prior to the initial visit.*****

Do you have the authorization number? YES NO Please list number of session authorized _____

Do deductibles apply for your visits? YES NO Amount _____

(Note: medical and mental health deductibles may differ and be calculated separate)

Has the deductible been met? YES NO If not the deductible will be charged until met.

Do you a co-payment? YES NO Amount or percent? _____

Are your sessions limited or unlimited? YES NO _____ # of session per year, if limited.

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Informed Consent Information & Permission for Treatment

Please review the information requested below. Your signature will indicate that you understand and accept the information contained in the Informed Consent Information and Permission for Treatment.

Your information, including your status as our client is kept strictly confidential. I respect your legal right to confidentiality and will protect your information with the proper care. Identifying information will not be released without your permission. All records will be maintained in a confidential manner. Consent forms will be required for the release of any information. State and Federal laws may require the release of information without written or verbal consent in the following specific situations: 1. Medical or Mental Health Emergencies 2. Clients become a danger to themselves (Suicidal thoughts/behaviors/attempts, severe depression, etc.) 3. Clients become a danger to others (Homicidal thoughts/behaviors/attempts). The person threatened and the police will be notified. 4. Any report or suspected child abuse or neglect (Physical or sexual). 5. Any report or suspected domestic violence. 6. A court order directing the release of information. 7. Any litigation initiated by the client related to treatment. 8. Any abuse of the elderly, with mental illness or who cannot care for themselves properly. 9. For children under 18 years of age, videotaping is done to ensure the safety and welfare of the child and/or for educational purposes.

Fees are due at the time of service delivery. Prices may be reduced for shorter time periods. Cash, check or credit cards are accepted forms of payment. Clients are responsible for payment of delivered services. We will make an attempt to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility including, but not limited to: deductibles, co pays, and any fee not covered by your insurance provider.

At times the need arises for extended sessions. People often report significant benefit from sessions lasting 1 1/2 hours. We are excited to offer these sessions as an added service to you. Insurance carriers often cover the first part of these sessions and the client is then responsible for the other half.

Service	Time/ Minutes	Cost	
Initial Intake	60	\$125	By signing this form I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed.
45 minute Individual session*	45-50	\$100	We require payment at the time of service. If you have a deductible or co-pay, payment is expected at the time of service. A \$5.00 charge will be assessed to your account if your payment is not received on that day.
45 minute session with a family	45-60	\$125	As a courtesy to you, our billing department will assist you in submitting your insurance forms. If, however, your insurance company does not pay the anticipated amount, you are still responsible for the total amount of the bill. Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment. Ultimately, it is your responsibility to know the benefits of your policy and any changes that may arise.
Group Session per Individual	90	\$40	
Group Session per Couple	90	\$45	
Marriage / Couple Counseling	45-50	\$125	If your insurance company requires a deductible, Center for Child and Family, PLLC will accept a payment of \$85.00 for each session until that deductible is met. This payment is also due at the time of each session.
Other Fees Associated with Services Not Paid by Insurance			In the event your account is not paid within 90 days or your balance exceeds \$500, collection proceedings will be instituted. If we have to refer your account to collections, you will be responsible for all costs of collections including reasonable collection agency fees, attorney fees, and court costs.
"No Show" Fee		\$100	
"Group No Show" Fee		\$50	If you have insurance, please understand that this is an agreement between you and your insurance company. <i>If your insurance company requires an authorization for your visits, please make sure that you have obtained this authorization prior to your first appointment. If your insurance company denies your visits for any reason, you will be responsible for the full fee of each of these visits at the rate listed above.</i>
"Late Cancel" Fee (24 hours or less)		\$65	
Return Check Fee		\$30	I have read and understand the above statements and agree to be bound by the terms in this policy. I have had the opportunity to ask questions about anything in this policy and have had my questions answered to my satisfaction.
Letter Writing		\$35/page	
Court Preparation and Court Reports		\$75/hour	I consent to release any personal or clinical information required to process my claim to my insurance provider listed on the back of this form. I also authorize any payments made by my insurance company to be paid directly to Center for Child and Family Counseling, PLLC. This form will be considered a signature on file for all future insurance claims. This release will expire 1 year from the date of your last appointment.
Court Appearance *** 120 minutes minimum	Minimum	\$300	
Telephone Consultation	15	\$25	

I understand and agree to the limits of confidentiality as indicated above. I agree to hold Center for Child and Family Counseling, PLLC harmless for any loss, cost or damages sustained by my spouse, child or me. By signing this form, I hereby authorize Janet Vessels, M.S. LPCC or the staff of the Center for Child and Family Counseling, PLLC to assess, diagnose and treat mental health and or substance abuse problems for myself, my family and or my child.

This acknowledges that I have receive a copy of the "Notice of Privacy Practices" for and received a copy for my files. Yes No

Date _____

Client Name-Print Please _____

Client Signature _____

Parent Signature/Adol/Child _____

Credit Card Authorization Form

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE.

Our primary goal is to take care of all expenses at the time of services. We keep a copy in your confidential record for the reasons below.

1. To bill any unpaid charges that may accrue as a result of having a deductible, co-payment, or coinsurance and or any other fees agreed upon that were not paid at the time of service delivery. Also to collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program or Managed care company.

2. To bill any Fail to Keep Appointment Fees or Cancellation Fees that are not paid by you through regular contact or billing.

3. Any NSF or Returned Unpaid Check amount plus returned check fees from your bank.

By providing the information below you agree to allow my office to bill the above mentioned fees and any other agreed upon fees located in the Informed Consent or Fee Schedule not paid by you in person, even if we are unable to contact you. You also agree that a \$5.00 per charge fee will be added for using your card for unpaid fees that are not paid through a written or verbal request. You also agree that all NSF or unpaid checks will be charged an extra \$25.00 charge plus the card fee. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card.

Name exactly as it appears on card _____

Type of Card (Visa and MC ONLY) _____ Visa _____ MasterCard

Card Number _____

Expiration Date Month _____ Year _____

Security Number (3 digits back of card) _____

IS billing address for card the same as home address? Yes No (If no fill in below)

Phone number for card Same as Home Phone Cell Phone Other _____

Client or Parent Signature _____ Date _____

By signing this I hereby understand that my card may be charged for reasons stated above.
would you prefer to use this card as your primary billing method if so please check here Yes No

Your Personal Concerns

Please describe the problem, in detail (who, what, when, where, how, why)

What do you believe may contribute to the problem?

List specific behaviors, thoughts, feelings or attitudes contributing to the problem

What has worked in the past to assist with this problem?

What have you tried that has not worked?

List people affected by the problem and how they are affected.

When does the problem seem the worst?

List all previous mental health or substance treatment or counseling with dates and names of providers including all hospitalizations with dates and providers

Have you ever thought about harming yourself in anyway? If you are filling it out for a child, have they ever talked about harming themselves? YES • NO •

If yes please list the details, including dates and circumstances:

Do you feel like harming yourself now or in the near future? If you are filling the out for a child, have they stated they wanted to harm themselves in the past two weeks? Yes • No •

If yes please list any details:

Do you feel like harming someone else right now? If filling this out for a child, have they stated they wanted to harm someone else? Yes • No •

If yes please list the details, including dates and circumstances:

Please list all drugs you/they use, including caffeine, alcohol and nicotine, any illegal drugs, prescription medication, the amounts, frequency and when you/they first began to use them:

Are there any medical issues that affect this behavior/problem?

If you/they now see or have been to a psychiatrist, medical doctor or therapist for this or a related mental health or medical problem please list the name, address and telephone number of the health professional on the release of information form.