BALANCED LIVING

Thank you very much for making an appointment with Balanced Living. Please fill out and sign this intake packet, including the payment information sheet, before your first appointment with us. We require all clients to leave a credit card, debit card or Health Spending Account (HSA) card on file. We will charge our late cancellation fee if you do not cancel within the required 24 hours' notice or no-show fee, as stated below in our Financial Policy.

Intake Checklist

Please use the following checklist to ensure you have completed the required forms.

- Adult Intake Form
- Insurance Information Form
- Payment Information Form
- Informed Consent Form
- Balanced Living Financial Policy

Thank you for taking the time to complete our required paperwork. We will be available to answer any questions you may have during your initial intake; you can also call us at 706.509.0130.

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CLIENT INFORMATION FORM

This Form is Confidential

Today's Date: _____

Your Name: _____
Last **First** **Middle Initial**

Date of Birth: _____ **Social Security #:** _____

Gender & Sexual Identity: _____ **Racial/Ethnic Identity:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer Name/Address: _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

- May I have your permission to thank this person for the referral? □ **Yes** □ **No**
- If referred by another clinician, would you like for us to communicate with one another? □ **Yes** □ **No**

Person(s) to notify in case of emergency: _____
Name **Phone**

_____
Relationship

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

What are your goals for therapy? _____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? -

_____

_____

_____

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*** The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing. ***

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use?YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO (Please list approximate dates and reasons): _____

_____

_____

Height_____ Weight (if applicable)_____Age_____Gender _____

Sexual & Gender Identity:___Heterosexual Lesbian Gay Bisexual Transgender
___Asexual ___In Question Other: _____

Racial/Ethnic Identity:

___African/African-American/Black____Latino/Latino-American___Bi-Racial/Multi-Racial
___American Indian/Alaska Native____Middle Eastern/Middle Eastern-American
___Asian/Asian-American/Asian Pacific Islander____White/European-American____Not listed

FAMILY:

How would you describe your relationship with your mother?

_____

How would you describe your relationship with your father?

_____

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Are your parents still married?_____If divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have?_____Ages?_____
How many brothers do you have?_____Ages?_____
How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship?_____How Long?_____Satisfaction?_____

Married/Life Partnered?_____How Long?_____Previously Married/Life Partnered? YES

NO

If so, length of previous marriages/committed partnerships _____

Do you have Children? If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: _____

_____

_____

Is spirituality important in your life and if so please explain: _____

_____

Briefly describe your diet and exercise patterns: _____

_____

EDUCATION & CAREER

High School/GED___College Degree____Graduate Degree (or Higher)_____
Vocational Degree What is your current employment? _____

Employment Satisfaction: 1 2 3 4 5 6 7 Any past career positions that you feel are relevant?

_____

_____

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What do you think are your strengths? _____

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety	→			People in General	→			Nausea	→	
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____

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INSURANCE INFORMATION

If you do not have insurance, please check this box:

☐**Self-pay—no insurance**

Responsible Party: Parent/Guardian Information *(if minor)*

First Name MI Last Name Relationship

Street Address City State/Zip

Phone No: (____)_____SSN:____-_____DOB_____/_____/_____

Employer: _____

If you have insurance, please complete the following and bring your insurance card to your appointment so that we may obtain a copy for verification purposes.

Primary Insurance and Policyholder Information

Name of Insurance:_____ID No:_____Group:_____

Policyholder's Name_____DOB_____/_____/_____

Employer: _____

SSN:_____-_____-_____Client's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other:_____

Policyholder's Address: ☐Please check box if same as client, or complete below if different.

Street Address City State/Zip

Secondary Insurance and Policyholder Information

Name of Insurance:_____ID No:_____Group:_____

Policyholder's Name:_____DOB_____/_____/_____

Employer: _____

SSN:_____-_____-_____Client's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other:_____

Policyholder's Address: ☐Please check box if same as client, or complete below if different.

Street Address City State/Zip

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign to Balanced Living Counseling Center, for services provided by Balanced Living Counseling Center, all coverage or other benefits available under any government program, insurance policy, Workmen's Compensation claim and other benefit program, and I direct that benefits be paid directly to Balanced Living Counseling Center. I agree that Balanced Living Counseling Center may receive benefits directly, which will discharge the insurer or benefit program to the extent of such payments. I hereby authorize Balanced Living Counseling Center and/or TheraNest (the billing service for Balanced Living Counseling Center), to release information as necessary to obtain benefits from this policy. I agree to pay promptly and fully all charges for services provided by Balanced Living Counseling Center according to the rates and terms. I hereby personally obligate the patient/client and myself, if signing as a spouse of the patient/client or as a parent/guardian of a minor patient/client, to pay off all such charges. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges, shall waive or release these personal financial obligations.

***I have read this form and have had an opportunity to ask questions concerning this form and its contents.**

Signature *(person with legal authority to sign for client if he/she lacks capacity and/or is a minor)* Date

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Payment Information

Client Will Complete Top Portion Only

Client Name as it Appears on Card:_____

Card Number:_____ **Expiration Date**:_____

Credit Card Billing Address:_____ **State/Zip code**:_____

Security Code (3 or 4 numeric digits):_____

Client Signature:_____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Office Use Only

Client Name:_____ **Date**:_____ **Insurance**:_____

Charge Amount:_____ **Revised Charge Amount**:_____

Session#	Date	Service Code	Amount Due	Amount Paid	Authorization Code	Date Posted	Check CC Cash	Credit	Total Remaining Balance	Recorders Initial

BALANCED LIVING

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

We are very pleased that you have selected us for your therapy needs, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with us is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

Balanced Living Counseling and Wellness Group was established in 2015. We currently have ten full time and part time mental health counselors and we also have a licensed massage therapist on staff. We believe in an integrative approach that embodies unique strategies focused on your physical, emotional, and mental wellness. We have a dedicated staff of mental health counselors that are prepared to work with you individually or as part of a comprehensive team. Our experienced staff utilizes individualized and creative techniques that provide our clients with tools and outlets for change. Our therapy rooms have been designed to provide you with a serene, discreet environment to help facilitate movement and progress. Our non-judgmental and experienced Mental Health Counselors have diverse professional backgrounds that help them understand you. We utilize up to date evidence-based techniques that are constantly molded towards your growth. Our counselors are committed to their personal growth through continuous education, and a dedication to their profession.

Theoretical Views & Client Participation

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with us at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things we talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without us. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, we will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that terminating therapy or transferring to another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit. We truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or we don't hear from you for one month, we will need to close your chart. However, as long as we still have space in our schedule, reopening your chart and resuming treatment is always an option.

Confidentiality & Records

Your communications with us will become part of a clinical record of treatment referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. In addition, your PHI will also be stored electronically with TheraNest, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, Federally approved encryption. Additionally, we will always keep everything you say to us completely confidential, with the following exceptions: (1) you direct us to tell someone else and you sign a "Release of Information" form; (2) we determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) we are ordered by a judge to disclose information. In the latter case, our license does provide us with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Please note that in couple's counseling, we do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Please Initial You Have Read This Page_____

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Structure and Cost of Sessions

We agree to provide psychotherapy for the fee of $125 per 60-minute session, $45 per 90-minute group therapy session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal and needing to talk to us between sessions may indicate that you need extra support. If this is the case, we will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at quarter hour increments of hourly fee. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

Cancellation Policy

We acknowledge that at times there are reasons for a cancelled/missed appointment due to emergencies, illness or obligations to work or family. However, when you do not contact us to cancel an appointment in a timely manner, we are unable to fill the appointment time with another client who may be in need of counseling. If you cancel your appointment within 24 hours of your appointment, we will add a $25 late cancellation fee to your account (barring any unforeseen emergency as described above). If you do not contact us and you miss your appointment, there will be a $50 no show/missed appointment fee.

In Case of an Emergency

Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 24 hours. However, we do not return calls, texts, or emails on weekends and holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Floyd Medical Center (Mental Health) at 706-509-6118
- Call Ridgeview Institute at 770-434-4567
- Visit a local Emergency Room
- Call 911

Professional Relationship

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, our relationship has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If we were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, our judgment needs to be unselfish and purely focused on your needs. This is why your relationship with us must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients confidential. For your confidentiality, we will not address you in public unless you speak to us first. We must also decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, we will not be able to be a friend to you like your other friends. In sum, it is my ethical duty as a therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Please Initial You Have Read This Page_____

BALANCED LIVING

Interaction with the Legal System

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counselor or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. If I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time that my therapist spends over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

Statement Regarding Ethics, Client Welfare & Safety

We assure you that our services will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association. If at any time you feel that we are not performing in an ethical or professional manner, we ask that you please let us know immediately. If we are unable to resolve your concern, we will provide you with information to contact the professional licensing board that governs our profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once we are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Technology Statement

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with us remains therapeutic and professional. Therefore, I've developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure or confidential. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with us.

Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. We realize that many people prefer to text and/or email because it is a quick way to convey information. **However, please know that it is our policy to utilize these means of communication strictly for appointment confirmations (nothing that could be inferred as therapy).** Therefore, please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality. If you do, please know that we will not respond. **You also need to know that we are required to keep a summary or copy of all emails and texts as part of your clinical record that address anything related to therapy.**

Facebook, LinkedIn, Instagram, Pinterest, Twitter, Etc.: It is our policy not to accept requests from any current or former clients on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your Confidentiality and blur the boundaries of your relationship. We do have a professional Facebook page where you are welcome to "follow" us. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to Balanced Living Counseling Center. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Google, Bing, etc.: It is our policy not to search for my clients on Google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself with us as you feel appropriate. If there is content on the Internet that you would like to share with us for therapeutic reasons, please print this material and bring it to your session.

Please Initial You Have Read This Page_____

BALANCED LIVING

Faxing Medical Records:

If you authorize us (in writing) via a "Release of Information" form to send your medical records or any form of protected health information to another entity for any reason, we may need to fax that information to the authorized entity. It is our responsibility to let you know that fax machines may not be a secure form of transmitting information. Additionally, information that has been faxed may also remain in the hard drive of our fax machine. However, our fax machine is kept behind two locks in our office. And, when my fax machine needs to be replaced, we will destroy the hard drive in a manner that makes future access to information on that device inaccessible.

Recommendations to Websites or Applications (Apps):

During the course of our treatment, we may recommend that you visit certain websites for pertinent information or self-help. We may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide and communicate to us if you would like this information as adjunct to your treatment or if you prefer that we do not make these recommendations.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

Our Agreement to Enter into a Therapeutic Relationship

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read and understand the contents of this **Information, Authorization and Consent to Treatment** form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you on our Website. Your signature also indicates that you agree to the policies of your relationship with us, and you are authorizing us to begin treatment with you.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable: _____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

BALANCED LIVING

Financial Policy

Thank you very much for making an appointment with Balanced Living. We cannot accept checks for the initial intake. With respect to all our clients seeking counseling services, please fill out and sign this Intake Packet, including the payment information sheet, before your first appointment with us. We require all clients to leave a credit card, debit card or Health Spending Account card on file. We will charge our late cancellation fee if you do not cancel within the required 24 hours' notice or no-show fee as stated below in our Financial Policy

You are ultimately responsible for your Balanced Living Counseling Center bill. If you have insurance coverage with an insurance carrier with whom we are in network, we will help you by providing services such verifying benefits and obtaining an estimate of coverage, filing claims, and providing whatever reasonable information your insurance company requests from us. Please be advised that working with your insurance company is a courtesy service provided by Balanced Living Counseling Center, and we cannot guarantee that your insurance company will pay. If you have insurance coverage with a company we are not in network with, we will provide you with a Superbill to submit for reimbursement after you have paid us for services.

Cancellation Policy

Your appointment has been reserved specifically for you. Once your appointment is scheduled, you will be financially responsible for it unless you provide **24 hours' notice** of cancellation. It is important to note that insurance companies do not provide reimbursement or payment for sessions you do not show up for**. You will be charged a fee of $25.00 for cancellations without 24 hours' notice and a fee of $50.00 for a No Show/No Call.**

$

Clients are expected to pay the standard fees at the end of each session unless other arrangements have been made. For clients using in-network insurance, the copay is due at the time of service.

Our fees are as follows:

- Initial Consultation -$150.00
- Individual and Couples -$125.00
- Tele-Mental Health-$125.00
- Telephone calls that exceed 10 minutes in duration will be billed at quarter hour increments of hourly fee.
- Writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same prorated rate, unless indicated and agreed upon otherwise.
- There is a $25 fee for any returned checks.
- Clients may not carry a balance for more than 30 days without prior arrangement.

Please Initial You Have Read This Page_____

- Any court-related services (preparation, consultation with attorneys, travel, court appearances, etc.), please see our Information, Authorization and Consent to Treatment form.
- If your account is overdue (unpaid) and there is no written agreement on a payment plan, we can use legal or other means (courts, collection agencies, etc.) to obtain payment.

Services may be covered in full or in part by your health insurance carrier. If you and/or the insured party has not met their deductible, you will be charged your insurance company's contracted rate.

Please verify your coverage prior to your appointment by asking the following questions:

- Do I have mental health insurance benefits?
- What is my deductible, and has it been met for this year?
- How many sessions per year does my insurance cover?
- What is my co-pay/co-insurance?
- Is a referral required from my primary care physician?

I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to my insurance company.

AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.

_____ _____

Client Date

_____ _____

Responsible Party, if other than client Date

_____ _____

Therapist Date

Please Initial You Have Read This Page_____