BALANCED LIVING

Thank you very much for making an appointment with Balanced Living. With respect to all our clients seeking counseling services, please have this Intake Packet filled out and signed; including the payment information sheet before you make 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.

MINOR INTAKE CHECKLIST

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

- o Child Intake Form
- o Insurance Information Form
- o Payment Information Form
- o Informed Consent Form
- o 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.

BALANCED LIVING

CLIENT INFORMATION FORM FOR MINOR CHILD

This Form is Confidential

Today's date: _____

Your Child's Name: _____
Last First Middle Initial

Child's date of birth: _____ Gender: _____

Parent or Legal Guardian's Name(1): _____
Last First Middle Initial

Parent or Legal Guardian's Social Security# (1): _____

Home street address (1): _____

City (1): _____ State (1): _____ Zip (1): _____

Parent or Legal Guardian's Name of Employer (1): _____

Address of Employer (1): _____

City (1): _____ State (1): _____ Zip (1): _____

Home Phone (1): _____ Work Phone (1): _____

Cell Phone (1): _____ Email (1): _____

Parent or Legal Guardian's Name(2): _____
Last First Middle Initial

Parent or Legal Guardian's Social Security# (2): _____

Home street address (2): _____

City (2): _____ State (2): _____ Zip (2): _____

Parent or Legal Guardian's Name of Employer (2): _____

Address of Employer (2): _____

City (2): _____ State (2): _____ Zip (2): _____

Home Phone (2): _____ Work Phone (2): _____

Cell Phone (2): _____ Email (2): _____

Are Parents/Legal Guardians divorced or separated? Yes • No

Please enter the Parent/Legal Guardian who is authorized to make non-emergency medical decisions based on the most current Custody Agreement: _____

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: _____

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so:

(Your Signature): _____

Please briefly describe your child's presenting concern(s): _____

_____

_____

What are your/your child's 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)? _____

*** 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

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 child's relationship with his/her mother? _____

How would you describe your child's relationship with his/her father? _____

Are your child's parents/legal guardians still married? If not, how old was the child with they separated/divorces, and how did this impact him/her? _____

Please describe your child's relationship with his/her grandparents: _____

Are there any other primary caregivers who have had a significant relationship with your child? If so, please describe how this person(s) may have impacted your child's life: _____

How many sisters does you child have? _____ Ages: _____
How many brothers does your child have? _____ Ages: _____
How would you describe your child's relationship with his or her siblings? _____

RELATIONSHIPS, SOCIAL SUPPORT, & SELF-CARE

	POOR						EXCELLENT
Child's current level of satisfaction with friends and social support:	1	2	3	4	5	6	7

How would you describe your child's relationship with his/her peers? _____

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

Please briefly describe your child's self-care and coping skills: _____

What are your child's diet, weight, and exercise/activity patterns? _____

Please briefly describe your child's school performance and experience: _____

What are your child's hobbies, talents and 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: _____

_____

_____

_____

INSURANCE INFORMATION

If you do not have insurance, please check here: _____ **Self-pay – no insurance**

Responsible Part: 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: _____ Member ID: _____ Group #: _____

Policyholder's Name: _____ DOB.: _____/_____/_____

Employer: _____ SSN: _____-_____-_____

Client's Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other: _____

Policyholder's Address (Please indicate if same as client or complete below if different):

Street Address City State/Zip

SECONDARY INSURANCE AND POLICYHOLDER INFORMATION

Name of Insurance: _____ Member ID: _____ Group #: _____

Policyholder's Name: _____ DOB.: _____/_____/_____

Employer: _____ SSN: _____-_____-_____

Client's Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other: _____

Policyholder's Address (Please indicate 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 Theranest, LLC, 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 it's content.**

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

Payment Information

Credit Card Authorization

Name as it Appears on Card: _____

Card Number: _____ Expiration Date: _____

Billing Address: _____

City: _____ State/Zip: _____

CVV/Security Number (3 or 4 numeric digits): _____

Credit Card Holder's Signature: _____

Client's Signature: _____

(Signature indicate that you agree to allow Balanced Living to make charges to above card without you present, and that you authorize Balanced Living to leave this card on file with Theranest)

Please obtain a Release of Information from the client if the name of the credit card holder and the client is different. This allows us to communicate about payment information only.

Parents Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me therapist immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child. If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment. One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapists regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides the therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child will be identified therapy clients with rights of psychological privilege unless a separate written contract is made to conduct family therapy mutually agreed to by the therapist and the parents. If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record as mandated by law.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession, to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below. Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to themselves or someone else even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused physically, sexually or emotionally – or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child – protective agency.
- I am ordered by a Court to disclose information with proper releases or other legal exceptions.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of – or might be upset by – but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I will keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I will NOT keep this information confidential from you. If your child tells me, or if I believe based on things I learned about your child, that your child is addicted to drugs or alcohol, I will NOT keep that information confidential.

Example: If your child tells me that he/she is having voluntary, protected sex with a peer, I will keep this information confidential. If your child tells me, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will NOT keep this information confidential.

You can always ask me questions about the type of information I would disclose. You can ask in the form of "hypothetical situations," such as:

"If a child told you that he or she was doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of the State of Georgia may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me and you agree not to request access to your child's written treatment records unless ordered by a Court or to transfer the record to another therapist who is serving your child. As provided elsewhere in this Informed Consent, I do not wish to be involved in the legal system or to speak with anyone regarding testifying in Court. If I am required to testify, I am ethically bound NOT to give my opinion about either parent's custody, visitation suitability, or fitness. Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me for those amounts stated otherwise in this Informed Consent.

Parent/Guardian of Minor Patient:

*Please initial after each line and sign below indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.
INITIAL:_____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.
INITIAL:_____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.
INITIAL: _____

Parent/Guardian Signature _____Date_____

Print Name _____

Structure and Cost of Sessions

We agree to provide psychotherapy for the fee of $225 for intake assessment and then $180 for subsequent sessions, per 50-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. Business hours at Balanced Living Counseling Center are weekdays at 8:00am-5:00pm. Services rendered out outside of these times or holidays are considered after hours. We are required to document after hours care with CPT codes 99050 and 99051. A fee applies to these codes and may not be covered by your insurance policy. We will know once your first claim has been returned. It is your responsibility to find out your insurance company's policies. 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 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.

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 and Instagram account 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.

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's Name (Please Print) Date

_____

Client's 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

Financial Policy

Thank you very much for making an appointment with Balanced Living. With respect to all our clients seeking counseling services, please have this Intake Packet filled out and signed, including the payment information sheet, before attending 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 Balance Living Counseling Center bill. If you have insurance coverage with an insurance carrier with whom we are in network, we will help you with your insurance coverage by providing services such as calling to verify 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 a courtesy service provided by Balance Living Counseling Center, and we cannot guarantee that your insurance company will pay. If you have insurance coverage with a company with whom we are not in network, Balance Living Counseling will provide you with a Superbill to submit for reimbursement after you have paid us for services.

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.

Fees

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.

The following is the list of fees charged:

- Initial Consultation - $225
- Individual and Couples - $180
- Tele-Mental Health- same as above
- 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.

- Therapist will charge a $25 fee for any returned checks.
- Clients may not carry a balance for more than 30 days without prior arrangement.

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 means such as courts, collection agencies, etc. to obtain payment. Business hours at Balanced Living Counseling Center are weekdays at 8:00am-5:00pm. Services rendered out outside of these times or holidays are considered after hours. We are required to document after hours care with CPT codes 99050 and 99051. A fee applies to these codes and may not be covered by your insurance policy. We will know once your first claim has been returned.

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 Initial You Have Read This Page_____

Please verify your coverage prior to your appointment and you can ask 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's Signature Date

_____ _____

Responsible Party's Signature (if other than client) Date

_____ _____

Therapist's Signature Date

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