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 for you and/or your family, please read and complete the information in this packet.

1. Client and Intake information.
2. Notice of Privacy Practices Handout is available online and in the office.
3. Please note that if more space is needed turn page over and continue there.
4. Please check out and review the Parent Handbook on our website.

<u>This Information is required before services are provided.</u>

Client and Intake Information

Full Name: _____ SS# _____DOB_____
Address: _____City_____ Zip_____

Home Phone Number _____ Cell _____Work _____

Emergency Contact _____Emergency Number _____

Parents Name, if a Child/Adolescents _____
Email: _____

Insurance Subscriber (individual whose insurance is providing the coverage) _____
(please include all alpha characters)

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 ☐

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

Is Preauthorization required? YES ☐ NO ☐ If yes, please continue below.

Have you been preauthorized for this visit? YES ☐ NO ☐

Do you have the authorization number? YES ☐ NO ☐ Authorization # _____

Please list number of session authorized _____

Do deductibles apply for your visits? YES ☐ NO ☐ Amount _____

Has the deductible been met? YES☐ NO ☐ If not, the deductible amount 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.

Is this an Employee Assistance Program (EAP) referral/Visit? YES ☐ NO ☐ How many visits on your EAP _____

A copy of the "Notice of Privacy Practices" is available on our website.

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.

WELCOME

Thank you for seeking services at the Abundant Living Psychological and Coaching Services. We look forward to serving your mental health care needs through an array of services available to you, your child and/or your family. "Informed Consent" is a legal document that outlines our general services. If you would like a copy of your signed document, please ask your counselor.

Provision of Services

I understand that the Abundant Living Psychological and Coaching Services and/or its independent contracted counselors offer a variety of clinical services to children, adolescents, and family/couples including: intake assessment, individual, crisis intervention, group counseling, supervised visitation, limited evaluations and testing, court testimony in the role of the person's mental health provider, workshops and referral. During the initial assessment, my counselor and I will work together to determine how best to serve my needs. I further understand that appropriate referrals will be provided to me if it is determined that I would be best served by another community resource.

Nature of Services

I understand that there may be both risks and benefits associated with participation in counseling. Counseling may improve my ability to relate to others, provide a clearer understanding of myself, my values, and my goals, and an ability to deal with everyday stress. Although counseling can be beneficial to many people, it may not be helpful for everyone. Therefore, it is essential that you discuss any questions or discomfort you might have with your counselor.

Confidentiality

I understand that Center for Child and Family Counseling Staff and counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective counseling sometimes requires that staff members share confidential information with other staff members.

I understand that no records or information about me will be released from this Center without my permission, **except under certain circumstances:**

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. If a valid subpoena is issued for my records or a signed court order by a Judge directs 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.

Attendance

I agree that while I am seeing a counselor or participating in a group/workshop, whenever possible, I will notify the counselor **at least 24 hours** in advance if I know I will miss a session. I understand that if I do not show for an individual session and do not call, it may count towards my allotted number of sessions for EAP services, where available. You may leave a message on our voice mail and email.

No Show/Late Cancel Policy

I agree that I understand the Abundant Living Psychological and Coaching Ssrvices has a 24-hour appointment cancellation policy, which states you must change or cancel your appointment at least 24 hours ahead of the scheduled time. We have a very high demand for our services and non-cancelled **(*No Show/Late Cancel)** appointments translate into missed opportunities for others in need of timely services. Please feel free to clarify this policy with your counselor. (***No Show*** *is defined as not calling to cancel your appointment or calling to cancel with less than 24 hours notice. There are a few exceptions such as a last minute illness or emergency.*) A Counselor may to waive the charge as their discretion.

Records
Your records may be stored "on paper" and/or electronically and include the information you provided and information about any interactions (individual/group counseling, phone calls, consultation, emails, etc.) with our staff. This information is only accessible within our office and computer systems. All employees sign confidentiality agreements or are required to maintain your privacy and confidentiality according to their license and ethical standards. Your financial records, billing information, is separate from your medical information. You, as the client, may receive one free copy of your records. Any records provided to attorneys, or others will be copied at a cost 0.35 cents per page.

Contact Us
Each Counselor may provide their personal cellular phone number or email to contact them. The office number is available for messages. Email may NOT be a completely confidential means to contact us. Counseling is not provided over email and is generally used for scheduling appointments or very brief questions.

Contacting You
In order to keep my relationship with my counselor confidential, the best way to contact me should the need arise is noted below. I am aware that information exchanged over a cell phone and e-mail could be intercepted by an outside party.

It is OKAY to leave a message		Please check all that apply	
Cell Phone	_____	YES ☐	NO ☐
Home Phone	_____	YES ☐	NO ☐
Work Phone	_____	YES ☐	NO ☐
Email address	_____	YES ☐	NO ☐

Financial Responsibility for Payment of Services
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. A $5 fee will be charged for using credit cards. 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.

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.

We require some form of payment at the time of service. If you do not know if you have a deductible or co-pay payment the Abundant Living Psychological and Coaching Services for Children and Adolescents, PLLC will accept a payment of $100.00 for each session until information is received on deductibles, co-pays and coinsurance.

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.

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.

If you have insurance, please understand that it is an agreement between you and your insurance company. ***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 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 Abundant Living Psychological and Coaching Services for Children and Adolescents, 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.

Consent for Treatment and Agreement for Financial Responsibility
I understand and agree to the limits of confidentiality as indicated above. I agree to hold Abundant Living Psychological and Coaching Services for Children and Adolescents, PLLC harmless for any loss, cost or damages sustained by my spouse, child or me. By signing this form, I hereby authorize Shambra Mulder, PhD, Licensed Psychologist of the Abundant Living Psychological and Coaching Services for Children and Adolescents, PLLC to assess, diagnose and treat mental health and or substance abuse problems for myself, my family and or my child.

I certify that I have read, understand, and agree to abide by the information outlined above concerning mental health services and the financial. I hereby give my consent to authorize the Abundant Living Psychological and Coaching Services for Children and Adolescents, PLLC to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

_____	_____	_____
Client/Parent Signature	**Date**	**Client Printed Name**

Credit Card Authorization Form

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/No Show Fees or late cancel (canceling with less than 24 notice) fees not paid by you through regular contact or billing. See Fail to Keep Appointment (*No Show)/ Late Cancel policy in "Informed Consent" form.

3. Any NSF fee or Returned Unpaid Check amount.

By providing the information below you agree to allow this 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 service charge fee will be added for charging your credit card. You also agree that all NSF or unpaid checks will be charged an extra $30.00 charge. 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 Card ____ MasterCard_____American Express _____Discover Card

Card Number _____ Expiration Date Month_____Year____ Security Code_____

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** □