NAME of person being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client is under 18, name of parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client date of birth \_\_\_/\_\_\_/\_\_\_\_\_

CURRENT HOME ADDRESS:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Street | Apt # | City | State | Zip |
|  |  |  |  |  |

TELEPHONE Number that is the best way to reach client/guardian.

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

While email and texting are convenient, I do not consider them confidential

\*due to HIPPA I cannot keep client’s names in my phone. Please include your first name last initial when texting Texts are erased nightly.

EMERGENCY CONTACT:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION: *no need to fill out if you provide me with a copy of your insurance card*

Insurance name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent page:

I authorize Teresa Schroeder, MA LPC CRC LLC to bill the insurance company for services of psychotherapy rendered.  Initials \_\_\_\_ Date \_\_\_\_\_\_\_\_\_

I agree that I am responsible for copayments, coinsurance, and fees associated with receiving

therapy services (including choosing not to use insurance) Initials \_\_\_\_ Date \_\_\_\_\_\_\_\_\_

I understand that I must communicate if I need to reschedule. If I reschedule the same day or will be charged a $50.00 fee. Initials \_\_\_\_ Date \_\_\_\_\_\_\_\_

I have been offered a copy of the Privacy Information HIPPA Initials \_\_\_\_ Date \_\_\_\_\_\_\_\_\_

I have read and understood the Office Policy handout. Initials\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

I understand that if I am in contact with another person/s who has active symptoms of Covid 19 or I the client have symptoms of Covid 19 I will communicate with Teresa Schroeder and will be offered telehealth as an alternative while in quarantine or recovery. Initials \_\_\_\_ Date\_\_\_\_\_\_

I believe that each individual is unique and has their own way of addressing resolutions. Thus, believe in a wellness model that helps clients empower themselves by focusing on what works for them and not in a systematic approach that provides a generic procedure on working on a treatment. One's journey is not the same as the other.

Client's Rights

* 1. The client may ask questions on what to expect during and the end of the therapy.
  2. The client may decline to proceed the therapy as to the techniques which may be conducted by the therapist.
  3. The client may cease to continue therapy anytime, without any impediment and may return to therapy anytime.
  4. The therapist has the right to dismiss the client from the course of therapy.
  5. The client has the right to review his or her records from the therapist.
  6. Right to confidentiality: Within limits provided for by law, all records and information acquired by the therapist shall be kept strictly confidential in accordance to the principles of a doctor-patient relationship. All information will not be shared or revealed to any person, agency, or organization without the prior written consent of the client.
  7. The client can raise any concerns and to speak with the therapist immediately of any concerns provided that the therapist is likewise available to discuss matters with the client.

I have reviewed this Professional Counseling Informed Consent Agreement. I likewise understand my Client's Rights set in this form.

I accept this agreement and consent to counseling.

I agree to psychotherapy services with Teresa Schroeder MA, LPC CRC LLC

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

Jotform.com

**Client copy**

**A note about your deductible....**.   
**I am finding in a lot of cases the insurance companies want you to pay for the full amount of the session until your deductible is met.   
  
This can be a larger bill than you were expecting!   
  
You may have a $20.00 to $50.00 copay but then have to pay another amount to cover the full rate that insurance reimburses of anywhere from $73.06-$110.50**  
  
**Please call member services on the back of your card to verify your benefits.**