Informed Consent & Statement of Understanding

CLIENT INFORMATION:

Name: _____DOB: _____
Address: _____ City:_____
State: _____ Zip: _____ Home phone: _____ Cell Phone: _____
SS# _____ Email: _____
Place of Employment: _____ Driver's License # _____
Job Title: _____ Business Phone # _____
Name of Spouse/Partner (guardian of child): _____ D.O.B_____
Place of Employment: _____ Job Title: _____
In case of emergency, whom should we contact?
_____
Phone #: _____ Relationship to patient? _____
Party responsible for payment of services: _____
Referred by: _____

PRIMARY CARE PHYSICIAN:

Name: _____ Physician Phone # _____

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. You have the right to confidential mental health care *except* in cases where the therapist believes you might cause harm to yourself, to someone else, or if child or elder abuse/neglect is suspected. In these cases, the therapist has a duty by law to file a report with the appropriate authorities. Also, therapists are required to testify when commanded to do so by a court ordered subpoena. If you run into me, your therapist, outside of the office, I will not acknowledge you. I do this to ensure your right to confidentiality. However, if you want to greet, visit with, or introduce me to your friends or family as a friend or your therapist, that is up to you. Clients take the lead in these situations.

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Dual Relationships: I will avoid a therapeutic relationship with a personal friend, education or business associate and will avoid the development of a personal, education or business relationship with a therapy client. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking websites.

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Emergencies: Medical and/or psychiatric emergencies should be directed to 911 if life or safety is threatened. I will return your call as soon as possible during regular working hours and no later than

the next working day. After hours and the weekend, please leave a message and I will get back to you the next business day. If I cannot be reached and this is a life-threatening emergency, please go to the nearest ER; do not wait for me to return your call.

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Initials

Telephone / Internet Counseling: Whether in crisis or not, a client may occasionally want to discuss an issue on the phone or by email. For this service there is a minimum $35.00 fee, which includes up to 15 minutes of Internet or telephone conversation. If it goes beyond that period of time, the client will be billed at a rate of $35.00 per 15-minute increments in addition. Lengthy e-mails (read / responded) will be charged a minimum fee of $35.00. Please do not assume that any e-mail sent will be read immediately as there are times I am not available to check my e-mail.

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Scheduling of Appointments: Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. **You will be charged $100 for missed appointments or appointments canceled without 24 hours advanced notice.** ***If you arrive late for your appointment, your session cannot be extended into the next client's time.*** This policy is designed to respect the time management and scheduling for all other clients and therapists impacted within the office.

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FYI about Health Insurance & Confidentiality of Records: This practice does not participate with any insurance plans. There may be a chance that services will be a reimbursable medical expense under your insurance company's coverage policy. If you wish to seek reimbursement from your insurance coverage for services, I will provide you with a receipt detailing information the insurance company requires for reimbursement. Please consider what the ramifications of submitting such a claim to your insurance company might be. In order for your therapy to be considered a covered medical expense, your therapist (or "provider" in insurance parlance) must give you a mental illness diagnosis according to the DSM (Diagnostic and Statistical Manual of Mental Disorders). When this information is submitted to your insurance company, it becomes part of your permanent medical record. Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Your therapist has no control over, or knowledge of, what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. Take this into consideration when deciding to use your health insurance to help pay for services.

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Fee Policy for Services: I provide individual and couples therapy for the fee of $120 per session. I charge $125 per hour for reports, letters, and other documentation. Any services I provide beyond your therapy session are charged to you directly at my hourly rate of $125 (charged in 15-minute increments). Court preparation and appearances begin at $300 per hour. Fees for other services provided upon request. All charges are your responsibility for the date of service. Any returned checks are subject to a $40 charge. Should your account be referred for collections, you agree to pay 6% interest plus a *$25* collection fee and reasonable attorney fees and/or court costs. If legal action becomes necessary, the cost of bringing the procedure will be included in the claim. If a client wants me to speak, meet, or

correspond in any way with any other person to include but not limited to an attorney, probation officer, CPS worker, physician, etc., the client will be billed for the therapist's time. **Payment is due at the beginning of your session. You may pay by cash, check or credit card.**

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Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of client records be requested unless otherwise agreed upon.

Should I be subpoenaed to testify in court regarding an issue with a client, this will necessitate that I clear my schedule to be "on call" for the court appearance. The charge for this is a minimum nonrefundable fee of $1200, payable in advance, regardless of whether I actually testify or appear in court. The first $1200 applies to a maximum of four hours of my time at an out-of-office courtroom rate of $300 per hour. Expenses I may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at an appropriate rate and are in addition to the $1200 minimum fee. If I am required to be on call beyond the first four hours for a court appearance, an additional $1200 minimum fee will be incurred, even if I must remain (on call) one minute, one hour, or all four hours beyond the first four. In other words, a $1200 minimum fee will be charged for any portion of a four-hour time slot in which I am required to be "on call" to testify in court, whether I actually am testifying or not. The client is responsible for these fees, not the court. Therefore, the client (or parents of a minor client) will be billed in advance.

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AUTHORIZATION AND RELEASE:

I have read the above Statement of Understanding & Informed Consent carefully; I understand and agree to comply. I fully understand that I am financially responsible for all charges whether or not paid by the insurance company. By signing this form I agree that I have read and understand these policies, give full consent for the completion of evaluation and provision of treatment as necessary, by the above named therapist, until otherwise notified. I also agree that I am financially responsible for any fees that are accrued for me or members of my family, including dependents who may or may not be over the age of 18, while under the care of my therapist. I further acknowledge that I have received notice of HIPAA policies.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____ _____
Patient/Guardian Signature Date

_____ _____
Colleen E. Neal Date