



Healing & Wellness Counseling, LLC

Located near 42nd between Grover and Center Streets
Omaha, Nebraska 68105

P: 531-222-6371

F: 877-991-5647

www.healandwell.com

Informed Consent, Professional Disclosure, and Policies

Thank you for choosing Healing & Wellness Counseling, LLC. The following information is provided to acquaint you with our policies and procedures. Your first appointment will take approximately 60-90 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, Nebraska and Federal Laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

I earned a Bachelor of Arts Degree from the University of Nebraska at Lincoln in 2000 and a Master's Degree in Community Counseling from the University of Nebraska at Omaha in 2010. I have been licensed by the State of Nebraska as a Licensed Mental Health Counselor since 2010 and am a member of the American Counseling Association. I have clinical training and experience in treating adults and couples. I use a comprehensive approach to treatment with cognitive behavioral – in particular Dialectical Behavioral Therapy, solution focused, and person-centered techniques to meet each individual's needs and goals.

Risks and Benefits to Counseling: Counseling can lead to better relationships, improved mood, and improved daily functioning. Counseling can lead to a reduction in painful feelings, problematic behaviors, and negative thinking. It may help you to resolve things that are distressing you or your family. These improvements and any "cures" cannot be guaranteed due to the many variables that affect these therapy sessions, and at times, counseling may bring up uncomfortable feelings. You may experience feelings including anger, frustration, sadness, and confusion. Counseling is best understood as a process and progress takes place over time. Treatment can involve weekly to bi-weekly sessions for a short period of time or up to several months or longer.

Confidentiality and Emergencies: Your verbal communication and clinical records are strictly confidential except for the following reasons: (a) information shared for payment purposes, such as to your insurance company for processing claims [*information requested may include types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc*] or to a collection agency [*information requested may include name, address, phone number, services provided, service dates, amounts due, etc*] (b) information you and/or your child(ren) report about physical or sexual abuse or neglect toward children or vulnerable adults (i.e. elderly, disabled/incompetent) [*if so, I am required by law to report this to the Department of Human Services*] (c) information indicating prenatal exposure to controlled substances, (d) information of non-emancipated minor clients [*parents or legal guardians have the right to access these records*] (e) specific information to share with another person or agency the client or legal guardian have authorized with a signed release (f) information you provide that informs me that you are in danger of harming yourself or others [*if so, I am legally required to warn the possible victim and notify legal authorities*] (g) information necessary for case supervision or consultation; note: my Professional Executors are my supervisor and a consult team member; they will contact you in the event of my death or becoming incapacitated (h) when required by law.

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Form: Informed Consent, Professional Disclosure, and Policies

Date Adopted: January 18, 2017

Date Updated: June 14, 2018

See Healing & Wellness Counseling, LLC's Notice of Privacy Practices for more information about the above exceptions to confidentiality and your rights.

Telephone Answering: There are times when I cannot personally answer the telephone. If your call is answered by my voicemail, please leave your name, phone number and a brief message. I will return your call as soon as possible. *If an emergency arises for which the client or their guardian feels immediate attention is necessary, please call my office phone and leave a message. If you receive no response from me within 10 minutes, the client or guardian understands that they are to contact the local emergency services in the community (Douglas County CMHC at 402-444-3375, any Hospital Emergency Department, the 24 hour Crisis Line at 402-717-4673 or 402-546-0770 or call 911). I will follow those emergency services with standard counseling and support to the client or the client's family. I reserve the right to charge for telephone services if they begin consuming significant amounts of my time; I will always tell you beforehand if I am going to start charging you. I cannot bill insurance for these calls so it will be your responsibility to pay these fees as applicable.

Mobile Phone Use: Cell phones can be very distracting during counseling or therapy. Please turn off your cell phone during our sessions or leave it in your car. There are exceptions to this policy, for example, if you are on call (Emergency Medical Technician, firefighter, law enforcement, physician, etc.) or if you have children you need to check on, you may keep your phone on with you.

Your Children: For safety reasons, children must be supervised during appointments. If your children are not involved in counseling, please make other arrangements for them. I cannot be responsible for supervising unattended children.

Appointments: You can expect your appointment to begin promptly. I appreciate your help in keeping the office schedule running timely and efficiently. Standard therapy appointments are 50 minutes in length.

If cancellation is necessary, please notify me as early as possible. Please note, depending on the circumstances, a late cancellation fee (50% of the hourly fee) may be charged if less than 24 hours notice is given or if the client simply does not show for an appointment. I CANNOT BILL INSURANCE FOR MISSED OR LATE CANCEL APPOINTMENTS, AND IT WILL BE YOUR RESPONSIBILITY TO PAY THE CANCELLATION FEE.

Appointment Reminder Service: I offer clients an option of signing up for reminders for upcoming appointments. Please indicate your preference regarding appointment reminders:

___ Please do not provide me with appointment reminders.

___ I would like appointment reminders.

Phone calls/texts to the following number: _____

Emails to the following email: _____

If you accept phone call reminders, messages may be left on voicemails. I acknowledge that confidentiality of information left via phone, text, or email cannot be guaranteed.

Signature _____ Date _____

Financial Policy: With your consent, I will bill your insurance company for therapy services provided. You are responsible for paying your co-pay or co-insurance.

I work with several insurance and managed care companies. Many have their own unique requirements for authorizing treatment sessions. I make every reasonable effort to understand your coverage and help you get the benefits your coverage offers.

At the same time, you are responsible to know and understand the benefits and limitations of your policy. You should know your co-pay amount; your annual deductible amount; your lifetime benefit; whether pre-certification of sessions is required; and, you should know if your coverage limits the maximum number of therapy sessions you can have each year.

Please be aware that most managed care companies take the following position: The authorization of services is not a guarantee of payment. Consequently, you are fully responsible for the portion of the bill not paid by your health care benefits plan.

My standard fee is \$106.22 for a 45 minute session and \$155.59 for a 60 minute session.

My priority is to provide you with the best possible service based on a friendly, business-like understanding between therapist and client. It is felt that misunderstandings can be minimized if financial policies are agreed upon from the very beginning.

- Payment at the time of each appointment is expected. If special arrangements are necessary, please discuss this with your therapist during the first appointment.
- I accept Visa, Mastercard, and Discover cards and cash; I do not accept checks. If planning to pay by credit card, please complete authorize Healing & Wellness Counseling, LLC to store your credit card information for future use:

I give Healing & Wellness Counseling, LLC permission to store my credit card information for future use.

Signature _____ Date _____

- Fees are charged for emergency, after-hours telephone calls and office consultations.
- Fees are charged for written letters pertaining to your treatment.
- Fees are charged when appointments are cancelled with less than twenty-four (24) hours notice or when the client does not arrive for a scheduled appointment.
- When a divorced, non-custodial parent is expected to pay for services to a minor, it is the custodial parent's responsibility to assure that payment arrangements are made. If there is a dispute or problem regarding fee payment, the parent who requested the services will be held responsible for those fees.

Primary Care Physicians: With your consent, I will coordinate care with your primary care physician (PCP) and/or his/her nurse(s). If you want this service please provide your physician's information here:

Physician Office _____

Physician Name _____

Physician Office Address _____

Physician Office Phone Number _____

Physician Office Fax Number _____

Please check the appropriate option below and sign and date where indicated:

___ I give permission for Melinda Cocolas of Healing and Wellness Counseling, LLC to contact my PCP to coordinate care.

___ I decline the option of having Melinda Cocolas of Healing and Wellness Counseling, LLC coordinate care with my PCP.

Signature _____ Date _____

Court Appearances: Recommendations regarding parental custody are outside my scope of practice and area of expertise. I do not provide or perform evaluations for custody, visitation, or other forensic matters. Therefore, it is understood and agreed that I cannot and will not provide any testimony or reports regarding issues of custody, visitation, or fitness of a parent in any legal matters or administrative proceedings.

If I am contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in), please note the following:

- I charge \$155.59 per 60 minute hour to prepare for and/or attend any legal proceeding and for all court related services. Please be prepared to pay in advance.

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- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions, and court appearances.
- If the court or attorneys do not pay my fee, you will be charged for the time I spend responding to legal matters.
- You will also be charged for any costs I incur responding to attorneys in your case, including, but not limited to the fees I am charged for legal consultation and representation by my attorneys.

I have read and I understand the above information. I have been given the opportunity to ask any questions and agree to follow these guidelines accordingly. You may have a copy of this form if requested.

Signature of client (or legal guardian of client)

Date

Melinda Cocolas, MS, LMHP, LADC

Date