CONSENT AND PATIENT INFORMATION

Name_____
FIRST MIDDLE INITIAL LAST

Birthday ____/____/____ Age____ Relationship status: ❑Married ❑Single ❑Divorced ❑Other: _____
Address_____City_____State_____Zip_____

Only list numbers and email addresses that you approve us to call, text, or email, identifying our self to whomever receives this communication as "Christian Counseling of McAlester".

Phone (____) _____- _____ Secondary Phone (____) _____- _____ **Email**: _____

Employer: _____Occupation: _____

Primary Care Physician: _____ ❑ *Signed Release* Psychiatrist: _____ ❑ *Signed Release*

Referred by / How did you hear about us?: _____

PARENT/LEGAL GUARDIAN _____
Parent Employer: _____ Parent Occupation: _____
Patient's Grade: ____ School: _____

INSURANCE

Insurance Company_____ Insurance ID# _____ Group#_____
Insured's Name _____ Insured's DOB ___/___/___ Insured's Employer _____
❑ *** We will need to Scan/Copy your Insurance Card ***

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS: I attest that I am the custodial parent or legal guardian of _____ and consent that he/she may be treated as a client by Duncan Counseling/Christian Counseling of McAlester.

INITIAL each paragraph to indicate you have been fully informed, understand, and agree:

___ **FINANCIAL/INSURANCE ISSUES:** I understand and acknowledge that I am responsible for all charges for services and materials, including those not covered by insurance. I give Duncan Counseling, LLC the right to keep my credit/debit card on file and to charge it for any unpaid fees. I understand that all known fees are due before each session. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held liable for any collection fee charged to our office to collect the debt owed. If at any time you have any questions regarding insurance, fees, balances or payments, do not hesitate to ask.
___ **24-HOUR CANCELLATION AGREEMENT:** I understand that counseling appointments are limited and another client may be on a waiting list for a session to open. I understand that if I do not cancel more than 24-hours before my appointment I will be charged and pay the full fee of the session.
___ **CONFIDENTIALITY**: I understand my verbal communication and clinical records are strictly confidential except for: a) information you and your child or children report about physical or sexual abuse; then, by Oklahoma State Law, this office is required to report this information to the Oklahoma Department of Children and Family Services, b) information shared with your insurance company to process your claims, c) where you sign a release to have specific information shared, d) if you provide information that informs your therapist that you are in danger of harming yourself or others.
___ **COMMUNICATION**: By signing below I give my permission to receive text messages or emails to confirm appointments and communicate with staff from HIPAA-Compliant sources.
___ **NEWSLETTER:** I consent to receive Duncan Counseling, LLC's (Christian Counseling of McAlester's) newsletter, containing news, mental health information, links to our site, links to external sites, and promotions by email or standard mail. You can unsubscribe at any time.
___ **EMERGENCY SITUATIONS:** If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian agrees that they will contact the emergency services in the community for emergency services (i.e. dial 911). I release Joel Duncan, LPC and Duncan Counseling (d.b.a. Christian Counseling of McAlester) of any liability for emergencies outside of my counseling session. I understand that Duncan Counseling, LLC does **not** take emergency or after-hours call. Duncan Counseling will follow any emergency services with standard counseling and support to the client or the client's family in a timely manner. **ODMH 24-hour Crisis Assistance 1-800-448-0740**

I understand, attest, and agree to the above. I understand that payment for services is due before each session:

Signature(s)_____ Date: ____/____/____

Revised 9/9/2015

FINANCIAL POLICY

Welcome to *Christian Counseling of McAlester*. Please read over our financial and missed appointment policy. If you have any questions, feel free to ask our staff.

We will always work with patients to keep their out-of-pocket expenses as affordable as possible.

Fees: Counseling sessions are typically 50 minutes long. The fee for a typical session is $75-$150 (service fees vary). **Payment is collected before your session at the reception desk**. We can automatically bill your credit/debit card at each session at your request.

Credit/Debit Card Guarantee: As you are responsible for all charges for services and materials (see pg 1 "FINANCIAL/INSURANCE ISSUES), including those not covered by insurance, our policy requires a Credit/Debit card be kept on file for each of our patients to guarantee their account, unless cash payments are made before each session. (Sign Credit/Debit Card Guarantee form)

Insurance Patients: If you have health insurance that covers our services, *Christian Counseling of McAlester* is happy to verify your benefits with your insurance company. We will also file your insurance for you. If your insurance covers a portion of your therapy, we will be happy to wait for 30 days for your insurance to pay their portion. You will, however, be responsible for your deductible, co-pay, and/or co-insurance. That portion of your care will be due before each appointment. You, of course, are responsible for all charges not covered by your insurance company. If at any time you have any questions regarding insurance, fees, balances or payments, do not hesitate to ask. Remember that deductibles restart at the beginning of each year for most insurances.

Self-Pay Patients: Patients without insurance, with high deductibles, or who do not wish to use their insurance are responsible for the total cost of their care. Payment in full is due before each session.

Advanced Payment Discount: You may be eligible for an Advanced Payment Discount if you self-pay. You may pay up to 20 sessions (10 sessions minimum) in advance and receive a 20% discount. Payment must be made before the prepaid visits. Let the receptionist or your therapist know you are interested in this discount.

Methods of Payment: *Christian Counseling of McAlester* accepts cash, check, debit cards, and major credit cards.

Missed Appointment Policy: 24-hour notice is required for cancellation of an appointment. Appointments not rescheduled or cancelled with less than 24-hours notice will be charged at your full session fee. (if we are filing insurance for you, your insurance carrier will not pay for your missed session). Your charge will be applied to your debit/credit card on file or to your prepaid balance.

Charges: Based on your current information, your fee due before each session will be: $_____
By signing below you agree to be responsible for any alterations that may change your out-of-pocket amount (ie. deductibles, insurance changes, etc.).

I have read and agree to and authorize the above terms and charges.

Signature(s)_____ Date: ____/____/____

Revised 9/9/2015

CREDIT/DEBIT CARD GUARANTEE FOR PERSONAL BALANCE

We require a Credit/Debit card for each of our patients to guarantee their account, unless cash payments are made before each session. You may choose the option below that fits your individual needs.

We will always work with patients to keep their our of pocket expenses as affordable as possible.

Check one or more:

❑ **Uninsured Patients**

Patient who are uninsured or whose insurance does not cover the cost of counseling because of high deductibles are other limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments while keeping your account current. A partial payment plan may be arranged as well (*sign Payment Plan Agreement*)

❑ **Insurance Assignment**

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. On Day 30, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be refunded to you.

❑ **Deductible Payment Plan**

Our Deductible Payment Plan is designed to keep your weekly expenses to a minimum. As a courtesy, our patients may pay out high deductibles at an agreed percentage of the deductible per visit. This percentage will continue to be billed to your credit/debit card each week until the full deductible is paid. Depending on the amount of the deductible and the length of time the patient is seen, this may extend after therapy is completed. Any overpayment will be credited back to the patient. (*sign Deductible Payment Plan Agreement*)

❑ **Insurance Co-pay**

Co-pays are due <u>before</u> each visit. Your co-pay will be charged to your designated credit/debit card if not paid by another method at the time of treatment.

I agree to the above terms and authorize you to charge payment to my credit/debit card on file.

_____ ____/____/_____

SIGNATURE DATE

Cardholder Name: _____

Card #: _____-_____-_____-_____ Exp Date: ____/____/_____ 3-digit CID #: _____

Revised 9/9/2015

CONSENT FOR COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

Date: _____

Name of Patient Making Request: _____

Primary Care Doctor Name: _____

Primary Care Doctor Location/Phone: _____

I acknowledge that this mental healthcare facility, in accordance with their Notice of Privacy Practices (NOPP) and the Omnibus HIPAA law, will release Patient Health Information derived from my treatment records to the physician listed above. I have reviewed the NOPP of this mental healthcare facility and have been given an opportunity to ask questions about it, understand it, and agree to its terms. A copy of this signed, dated consent shall be effective as the original.

I release, hold harmless, and agree to indemnify this mental healthcare facility, its employees, and its agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.
I specifically authorize this mental healthcare facility to use and disclose verbally, by mail, fax, or encrypted email the following type of super-confidential information as stated in the NOPP:

_____ Psychotherapy Records
(Initial)

I also understand that I may withdraw my consent at any time by informing this office in writing.

Patient Signature: _____ **Date: _____**

Patient Name (Please Print): _____

-OR-

Representative's Signature: _____ Date: _____

Representative Name (Please Print): _____

Relationship to Patient: _____

POLICY REGARDING TESTIMONY

Christian Counseling of McAlester (Duncan Counseling, LLC) has a policy against therapists testifying as a non-party witness in legal proceedings about therapy sessions with you, your partner, and/or your child. This is true even when you are the one requesting me to testify.
If you are currently involved in (or think you'll become involved in) litigation of any kind, including a divorce or a child custody case, please let me know immediately.

Below are some of my reasons for choosing not to provide testimony.

1. **Confidentiality is essential to therapy**. As a psychotherapist, my job is to develop a trusting relationship with you so you can share personal information without fear of judgment. Without your trust, treatment is much less successful. My policy allows my clients to trust that I won't reveal their confidences unless legally required to do so.

2. **My testimony may be harmful to your progress in therapy.** In therapy, I use an approach called "unconditional positive regard" to support you as you make important changes. When testifying, I have a duty to answer questions from a more objective viewpoint. This creates a conflict of interest. Hearing unexpected or unfavorable testimony can damage clients' trust in me and undo our work.

3. **I am a biased witness not likely to help the court.** As a treating psychotherapist, my clinical role is to develop a strong alliance with and bias in favor of my clients. As a result, I'm not able to be a neutral, expert witness regarding your case. My usefulness as a fact witness is also limited for this reason.

4. **Testifying is very disruptive to my practice**. Psychotherapy clients are often in distress. Having to cancel appointments can be harmful to my other clients. Also, it can be difficult to meet my financial obligations when I don't see my clients as scheduled.

_____
Client Initials

AGREEMENT NOT TO SEEK TESTIMONY

I hereby acknowledge that _____ ("Therapist") has informed me how involving a treating psychotherapist as a non-party witness in legal proceedings can create conflicts of interest and negatively impact therapy, reducing the possibility of a successful treatment outcome.

I also acknowledge that involving Therapist as a non-party witness in legal proceedings would be disruptive to his/her practice and unfairly impose upon him/her.

It is with this understanding that I hereby agree**,** as a condition upon which Therapist has consented to provide therapy, that I (or my legal representative) will not call, subpoena, or otherwise seek to compel Therapist to provide oral or written testimony as a non-party witness in a legal proceeding with respect to his/her assessment, evaluation, or treatment of me, my partner, or my child.

I agree that such attempts to seek Therapist's testimony as a non-party witness shall constitute a basis upon which a court should quash any subpoena or issue a protective order, and I agree to be responsible for and to pay for any attorney fees and costs incurred by Therapist or Duncan Counseling, LLC in attempting to secure enforcement of, and compliance with, this agreement.

I also agree that Therapist, whether in the role of fact or expert witness, is entitled to recover from me his/her current professional rate of $500 per hour for any time he/she spends providing, preparing to provide, or travelling to provide oral or written testimony as a non-party witness in a legal proceeding in which I or my representative seek his/her testimony. This includes testimony compelled by a court order.

Finally, I agree to deliver to Therapist a retainer of $2,000 before he/she provides any oral or written testimony as a non-party witness in any legal proceeding in which I or my representative seek his/her testimony.

_____ _____ _____

Client Signature Date

CHRISTIAN COUNSELING OF MCALESTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

□ We weren't able to communicate with the patient.

□ Other (please provide specific details) _____

_____ _____
Therapist Signature Date

Revised 9/9/2015