Counseling Services, LLC
2575 Spring Arbor Rd., Suite 300
Jackson, Michigan 49203
517-788-8330 (office), 517-788-9768 (fax)

Client Information:

Client Name:				Date:	
Address:					
City:		State:		Zip Code:	
SSN:		Birthdate:			
Phone #s (Home):		(Cell):		(Work):	
Email:					
**** Will you accept appointment reminders and/or messages to your cell or email?*** ☐ ***Yes*** ☐ ***No*** ***(Standard text messaging rates may apply)***					
In Case of Emergency:					
Contact Name:		Contact Number:		Relationship:	

Please Complete Parent/Guardian Information if Client is a Minor:

Name:					
Address:					
City:		State:		Zip Code:	
Relationship to Client:		Contact Number:			

Insurance Cardholder Information:

Policy Holder Name:			
Policy Holder Address:			
Employer:			
Policy Holder SSN:		Policy Holder Birthdate:	
Insurance Company:			
Contract Number:		Group Number:	
Copay Amount (If known):			
***I give my consent for this office to bill my insurance company and I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of mental health benefits to my therapist for services rendered.**			
Policy Holder Signature:		Date:	

Please tell us how you were referred:

****We need to make a copy of your Identification and Insurance Cards****

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Consent for Treatment

I, _____ , do herby seek and consent to take part
[*Client / Guardian Printed Name(s)*]

in treatment by, _____.
[*Therapist*]

I understand that developing a treatment plan with this therapist and regularly reviewing our work towards meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for services already rendered. I understand that I may lose other services or may have to deal with other problems if I stop treatment. Example: If court ordered treatment, I will have to answer to the court.

I know I must call to cancel an appointment with a minimum of 24 hours' notice of the appointment time. If I fail to call to cancel and do not show up, a fee may be assessed.

I am aware that an agent of my insurance company, or other third-party payer may be given information about the type(s), cost(s), date(s) and provider (s) of any services or treatment I have received. I understand that if payment for services rendered to me are not made, the therapist may discontinue my treatment for nonpayment.

My signature below shows I understand and agree with the above statements.

Client / Guardian Signature(s) **Date**

Printed Name(s) **Relationship to Client**

I, the therapist, have discussed the statements above with the client (and/or parent or legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist Signature **Date**

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Consent for Use of Personal Health Information (HIPAA)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive a revised copy within 60 days of that change. You may obtain a copy of out notice at any time by contacting your therapist.

You have the right to request that we restrict how protected health information about you is used or disclosed for mental health care, treatment plan and payment. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for mental health care, treatment plan and payment. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Signature **Date**

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Fee Agreement and Information

Our basic hour fees range from $100.00 to $200.00 per hour for ongoing therapy.

All payments for services rendered are your responsibility including co-payments, deductibles or any insurance denials. As a service to you we are willing to bill your insurance directly or provide you with a completed insurance form. Please provide complete insurance information so that we can avoid the possibility of your insurance denying reimbursement. It is also your responsibility to verify coverage, yearly deductible and to know your co-pay amount. This can be done by your employer's human resource department or calling the insurance department directly. You will need your insurance contract/ID number and birthdate of the policy holder. If you have any questions, we would be glad to help.

Parents/Guardian's with shared custody, payment arrangements are to be billed per custody agreement on file. Credit cards on file will be charged within 24 hours of your child being seen if other arrangement's (i.e. cash, credit card, check) from present parent have not been made with your child's counselor.

- Upon signing this agreement, I acknowledge that I have read and thoroughly understand the contents, and am willing to fulfill any financial obligation that may be incurred.

- I give my consent to this office to bill my insurance company and authorize the release of any medical or other information necessary to process my insurance claims. I also authorize payment of mental health benefits to my therapist for services rendered.

- I understand that I have a co-pay that is set by my insurance company, and that is due at the time of service.

Signature of Client, Parent or Guardian **Date**

Witness **Date**

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FEE SCHEDULE FOR NON-THERAPY SERVICES

During the course of treatment, there are some non-clinical services that may be requested by you or your legal representative. The costs of these services are NOT covered by insurances. Therefore, non-clinical services will be billed at the following rates:

No show/missed appointment without 24 hours notice:

Each Occurrence	-	$50.00

Response to emails, messages, inquiries of a non-crisis nature:

Less than 15 minutes	-	No Charge
15 – 30 minutes	-	$15.00
31 – 45 minutes	-	$30.00
Greater than 45 minutes	-	$45.00

Completion of letters or reports to Attorneys, Probation Officers, Physicians, etc.:

Per Request	-	$25.00

Court Testimony (calculated from office departure to return):

Per Hour (1 hour minimum)	-	$100.00

Records Requests:

(Michigan Law, rule 333.26269, Fee. Sec. 9. (1) Except as otherwise provided in this section, if a patient or his or her authorized representative makes a request for a copy of all or part of his or her medical record under section 5, the health care provider, health care facility, or medical records company to which the request is directed may charge the patient or his or her authorized representative a fee that is not more than the following amounts: (a) An initial fee of $20.00 per request for a copy of the record. (b) Paper copies as follows: (i) One dollar per pager for the first 20 pages. (ii) Fifty cents per page for pages 21 through 50. (iii) Twenty cents for pages 51 and over. (c) If the medical record is in some form or medium other than paper, the actual cost of preparing a duplicate. (d) Any postage or shipping costs incurred by the health care provider, health facility, or medical records company in providing the copies.)

I am aware that the above fees can / will be charged when the service is provided.

Signature Date

Therapist Signature Date

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Mental Health / Primary Care Physician Communication Form

Client Name: _____ DOB: _____

I ☐ **Do** / ☐ **Do Not** authorize: _____
(Check One) **(Therapist's Name)**

and my Primary Care Physician (PCP):

_____ _____
(PCP's Name) **(PCP's Address)**

_____ _____
(PCP's Phone #) **(PCP's Fax #)**

to exchange information regarding my mental health treatment and medical health care for the purposes of treatment coordination as may be necessary for the administration and provision of my healthcare coverage. The exchange may include information on mental health care, such as, diagnosis and treatment plan. I understand that this authorization shall remain in effect for one (1) year from date of my signature below or for the course of my treatment, whichever is greater.

I understand that I may revoke this authorization at any time by written notice to the identified therapist. I also understand that it is my responsibility to notify my therapist if I choose to change my Primary Care Physician.

_____ _____
(Signature of Client, Parent or Guardian) **(Date)**

Provider Information

(To Be Completed by Therapist)

DSM-V (ICD-10) Diagnosis and Name: _____

Treatment Plan Type: _____

Estimated length of treatment: _____ Frequency: _____

_____ _____
(Therapist Signature) **(Therapist Printed Name)**

If authorized, a copy of this form will be sent to your Primary Care Physician (PCP).

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Client History Form

1. What do you hope will be different in your life as a result of attending therapy?

2. How will you know when you have achieved your goal(s)?

3. Have you ever experienced mental health symptoms before? If so, what was your experience like? When did it happen?

4. Has anyone in your family ever experienced mental health or substance use issues? If so, please describe.

5. Do you have any current medical issues? If so, what are they? Are you seeing a physician or other healthcare professional for them?

6. Are you currently prescribed any medications? If so, please list the name, dosage, frequency and prescriber for each medication.

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Client History Form (Continued)

7. Do you have any concerns about substance use? If so, please list the substances and describe your concerns.

8. Do you have any concerns about relationships in your life? If so, which relationships are concerning? How are they concerning to you?

9. What social or individual activities do you engage in? How do you like to spend your leisure time?

10. Are there spiritual practices and/or cultural influences that are important to you? If so, please list them.

11. Were there any developmental concerns when you were a child? (e.g., delays in development, school difficulties, social interaction concerns, etc.?)

12. Do you have any current legal issues (including divorce/custody, etc.)? If so, please describe them.

13. What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful? What else is important to know about you?