



Parent/Guardian and Minor Intake Information

Date: _____

Welcome to Eagle's Landing Christian Counseling Center! We know that you have many options for behavioral health care, and we appreciate your choosing our team to assist you. On the following pages, please take time to tell us about you. Please complete this before your first session and your counselor will then review this information together with you in your first and subsequent sessions.

Because parents are vital to the treatment of their children, and because parents will be entering the counseling room and sharing confidential information about themselves and their child, we require all parents attending also complete an intake form for themselves as well as for the child. This is for your own protection under HIPAA.

Minor Child's Name: _____ Birth Date: ____/____/____

Parent Name: _____ Birth Date: ____/____/____

Gender: M F Age: _____ Ethnicity: _____

Telephone: Mobile: _____ Work: _____ Home: _____

Address (No. & Street/P.O. Box): _____ Apt. _____

City: _____ State: _____ Zip: _____

We currently give telephone calls for appointment reminders. What number would you prefer we call to leave a message? # _____

Religious Affiliation: _____ Church: _____ Active: Y N

Employment Status: Full-time Part-time Unemployed Retired

Occupation: _____ Employer: _____

Years of Education: High School Trade School College Graduate School

Degree(s) Earned: _____ Current Student: Y N Full-time Part-time Yr. _____

School (If presently enrolled): _____

Military Service: Y N Branch: _____ MOS: _____ Discharge Date: _____

In case of emergency, please contact: Name: _____

Relationship: _____ Telephone: _____

Referred by: _____



Are you currently seeing another counselor or psychiatrist? Y N
If yes, Name: _____ Phone: _____

Have you been in counseling before? Y N If yes, when? _____
With whom? _____ Was it helpful to you? _____

Health Information

Rate your current physical health: Excellent Good Average Declining Poor

Height: _____ Weight: _____ Recent Weight Changes: (lbs) lost: _____ gained: _____

Do you have any illnesses, injuries, or disabilities (past or present – including problems at birth) that we should know about:

Name of Primary Care Physician/Clinic: _____

Address: _____ Telephone: _____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes ____ No ____

Please list ALL medications (prescription or over-the-counter) that you are currently taking (If necessary, use additional page to list ALL current medications.):

What kinds of physical exercise do you get? How often? _____

How much caffeine do you consume each day? _____

Do you try to restrict your eating in any way? How? Why? _____

Substance Use

Have you used any tobacco products in the last 12 months? Yes No

How many standard drinks containing alcohol do you have on a typical day? (1 standard drink is .6 oz of alcohol)

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

Women: How many times in the past 12 months have you had 3 or more drinks in one setting?

___ 25 or more times ___ 13-24 time ___ 6-12 times ___ 1-5 times none

Men: How many times in the past 12 months have you had 5 or more drinks in one setting?



__ 25 or more times __ 13-24 time __ 6-12 times __ 1-5 times none

Do you participate in any risky behaviors? Yes No If so, what kind? _____

Marital Status: Single Engaged Married Separated Divorced Widowed

Name of Spouse: _____ Age: _____ How long married? _____

Children:

Name	Age	Gender	Grade	Health
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1. _____
2. _____
3. _____
4. _____

Spiritual Information:

I consider myself: Christian Jewish Buddhist Muslim Hindu Agnostic Atheist Other Unknown

I am happy with my current spiritual journey: Yes No Why? _____

I am active in the practice of my faith: Yes No Why? _____

I am visiting a Christian Counseling Center because: (Circle the number of all that apply)

- 1) I hope to get counseling from a Christian perspective;
- 2) I am open to hearing a Christian perspective on my issues;
- 3) I was referred here by a friend who was helped and hope to have the same good result;
- 4) This is a Christian counseling center? What does that mean?

For Women Only: (men skip to "Checklist of Concerns")

At what age did you start to menstruate (get your period)? _____

How regular are your periods? _____ How long do they last? _____ Heavy ____ Light _____

How much pain do you have? _____ Other experiences during period: _____

PMS experiences: _____

If your menopause has started, at what age did it start? _____ What menopausal signs or symptoms have you experienced? _____

Have you had a hysterectomy? Y N At what age? ____ Are you taking Hormone Replacement Therapy? Y N Type: _____

Please list all of your pregnancies and what happened with these pregnancies (your age, type of birth, miscarriage, abortion, any problems): _____



Parent Checklist of Concerns (Self):

Circle any LOSSES that you have experienced:

Death of: spouse child father mother sister brother grandmother grandfather friend;

Divorce	Abortion	Career/Job loss
Separation	Infertility	Other: _____
Broken engagement	Bankruptcy	
Miscarriage	Homelessness	

Circle any of these EXPERIENCES you have had in your life:

Child abuse: Physical, Emotional, Sexual, Incest From: Father, Mother, Sibling, Stepfather, Stepmother, Step Sibling, Uncle;

Spouse abuse: Physical, Emotional, Sexual, From which relationship? Spouse's drug or alcohol problems; Spouse's mental illness; _____;

From Parents: divorce; drug or alcohol problems; mental illness; Foster care; Abandonment; Rape; ; Assault; Suicide attempt;

Other: Auto or industrial accident; Major illness; Robbery Major surgery; Other: _____

Circle any PROBLEMS that concern you now:

Relationships	Dependency	Temper
Alcohol	Communication	Self-control
Drugs	Career	Loss of Appetite
Binge eating	Sex	Memory
Diet or exercise	Self-esteem	Parenting
Work too much	Health problems	Finances
Shopping	Sexual thoughts	Nightmares
My Anger	Anxiety	Concentration
Loneliness	Stress	My thoughts
Suicidal-thoughts	Energy	Feelings
Procrastination	Legal matters	God
Depression	Sleep problems	Other: _____
Grief	Relaxation	
Mood swings	Fear	

Reason for Today's visit:

In your own words, briefly describe the main problem which prompted you to seek counseling at this time:



Child/Adolescent Intake Form
(To be completed by parent or by adolescent when appropriate)

Parent/Guardian Name (Please Print):

Name: _____ Relationship to child: _____

Child/Adolescent (Patient) Information

Name: _____ Date of Birth: ___/___/___ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____ Parent Phone: _____

Gender: M F Age: _____ Ethnicity: _____

Religious Affiliation: _____ Church: _____ Active: Y N

Are there cultural issues I should be sensitive to?: Y N Explain: _____

School: _____ Grade: _____ Performance: Excellent Good Poor

Is this child currently seeing another counselor, psychologist, or psychiatrist? Y N

If yes, Name: _____ Phone: _____

Has this child ever been in counseling before? Y N

If yes, when and how long? _____

Was it helpful? Y N Explain: _____

Child's Medical Information:

Name of Primary Care Physician/Clinic: _____

Address: _____ Telephone: _____

Rate child's current physical health: Very good Good Average Declining Poor

Height: _____ Weight: _____ Recent Weight Changes: (lbs) lost: _____ gained: _____

Were there complications with pregnancy? Y N Explain: _____

Were there complications at birth? Y N Explain: _____

List all important illnesses, injuries, or disabilities (past or present): _____

Please list ALL medication (prescription or over-the-counter that your child is taking or has taken in the last six months. (If necessary, use additional page to list ALL medications):



Does your child exercise? Y N How and how much? _____

Does your child consume caffeine, sweets, or junk food? Y N How much? _____

Does your child eat well? Y N Any changes? _____

Does your child sleep well? Y N Any changes? _____

Has your child ever experimented with drugs or alcohol? Y N

Does anyone in your family use drugs or alcohol? (past or present) Y N

Who lives in your home? (Use another page if necessary)

	Name	Relationship to Child	Age	Gender
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Note other significant relationships (step-parents, step-siblings, etc.)



Child/Adolescent Checklist of Concerns:

(Check all that apply to any family member and indicate to whom it applies)

<input type="checkbox"/> Abuse (Emotional)	<input type="checkbox"/> Abuse (Physical)	<input type="checkbox"/> Abuse (Sexual)
<input type="checkbox"/> Abuse (Verbal)	<input type="checkbox"/> Abuse (Other)	<input type="checkbox"/> Anger/Temper
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Attention, Concentration, distractibility	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Communication	<input type="checkbox"/> Confusion	<input type="checkbox"/> Compulsions (specify _____)
<input type="checkbox"/> Cruelty to animals	<input type="checkbox"/> Death of someone close (or a pet)	<input type="checkbox"/> Decision making/indecision
<input type="checkbox"/> Developmental Delays (specify _____)	<input type="checkbox"/> Depression, sadness, low mood, crying	<input type="checkbox"/> Emptiness
<input type="checkbox"/> Extended family issues	<input type="checkbox"/> Fear of failure	<input type="checkbox"/> Fatigue, low energy
<input type="checkbox"/> Fearfulness, phobias (specify _____)	<input type="checkbox"/> Financial stress in the home	<input type="checkbox"/> Fire setting
<input type="checkbox"/> Friendships/Social relationships	<input type="checkbox"/> Grieving a loss (specify _____)	<input type="checkbox"/> Guilt
<input type="checkbox"/> Hallucinations/Delusions	<input type="checkbox"/> Headaches	<input type="checkbox"/> Health, Illness, Medical concerns, Physical Problems
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Chores – Quality, Schedules, Sharing Duties	<input type="checkbox"/> Inferiority feelings
<input type="checkbox"/> Impulsivity, loss of control, outbursts	<input type="checkbox"/> Irresponsibility	<input type="checkbox"/> Judgment problems
<input type="checkbox"/> Legal matters, charges, suits	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Low frustration tolerance
<input type="checkbox"/> Memory problems	<input type="checkbox"/> Menstrual problems/PMS	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Motivation/laziness	<input type="checkbox"/> Natural Disasters (tornado, flooding, fire, etc.)	<input type="checkbox"/> Neglect issues
<input type="checkbox"/> Obsessions (specify _____)	<input type="checkbox"/> Oversensitivity to criticism	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Pessimism	<input type="checkbox"/> Poor hygiene, poor self-care
<input type="checkbox"/> Procrastination/work inhibitions	<input type="checkbox"/> Self-centeredness	<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Self-mutilation	<input type="checkbox"/> Sexual issues (specify _____)	<input type="checkbox"/> Shyness
<input type="checkbox"/> Sleep problems (nightmares, night terrors, waking at night, difficulty going to sleep)	<input type="checkbox"/> Spiritual concerns	<input type="checkbox"/> Stress
<input type="checkbox"/> Suspiciousness	<input type="checkbox"/> Suicidal thoughts/plan/attempt	<input type="checkbox"/> Threatens to harm people, property, animals
<input type="checkbox"/> Trauma	<input type="checkbox"/> Violence	<input type="checkbox"/> Withdrawal/Isolation

Summary of the reason your child/adolescent is coming to counseling:

Informed Consent for Financial Policy and Contract for Professional Services



Thank you for choosing **Eagle's Landing Christian Counseling Center** as your Biblically rooted, professional mental health provider. We are committed to the success of your treatment. We are a non-profit organization. While keeping fees as low as possible, our counselors still need to be reimbursed for their services. Lower cost consultation is available from time to time with our interns. Below you will find the details of our financial policy. A signed agreement to this policy is required before beginning treatment.

1-A. GENERAL FINANCIAL POLICIES FOR ALL CLIENTS:

- Payments are due at the time of service. Please pay the receptionist or service provider before your meeting. We accept payment by cash, check, debit, Visa, Discover, and MasterCard.
- **A \$35.00 fee is charged for any checks returned from the bank for any reason and is due in cash at your next session.**
- If you are using an insurance company that we accept, we will bill your insurance company for you. Clients are responsible for all payments, including co-pays, at the front desk, before seeing their counselor. In order to maintain standing appointments, your account must remain current.
- All checks should be made payable to: Eagle's Landing Christian Counseling Center, or ELCC.
- Sessions are 45 – 60 minutes long. A session lasting 1 ½ hours long is considered 2 sessions.
- Phone conversations that exceed 20 minutes in length may be charged a one-session fee and will not be covered by insurance.
- We do not keep cash in the office and we are unable to make change of more than \$20 for \$100 bills.

1-B. MISSED OR CANCELLED APPOINTMENTS:

- Please help us better serve you by keeping scheduled appointments. If you are not going to keep your appointment, please allow time for the therapist to offer the appointment to someone else.
- **You will be billed for missed appointments and appointments that are not cancelled 48 hours in advance. Insurance companies will not reimburse for missed appointments. You will be expected to pay a \$65 missed appointment fee.**
- Failure to pay may impact your credit and you may be required to keep a credit card on file to bill for copayments and missed appointments.
- Exceptions will be made in the event of an accident or an emergency [i.e., breaking down, sudden illness, or sudden illness of a minor child, etc. Please note that "having to work" is not considered an emergency.]
- If you, or a family member, pay for a session in advance that you subsequently do not use, you will not receive a refund. However, you may apply it to future sessions.

1-C. LATE ARRIVALS OF CLIENTS AND/OR THERAPIST RUNNING LATE:

- We understand that sometimes things happen and you may arrive late for your appointment. We will do our best to give you your full 45-60 minutes session as long as it doesn't cut into the next client's time. Please understand that we try to stay on schedule as much as possible. By the same token, we are counselors dealing with people and their feelings and occasionally we have urgent situations. Therefore, sometimes we may run late. It is the counselor's prerogative to reschedule you or to continue to run behind by taking some of the next scheduled session to give you your 45-60 minutes. If you choose to leave before 30 minutes of your session time has passed, you are still expected to pay for the session. Please understand that we do our best to treat people as people, not appointments. Please respect our counselors by understanding that they are people too.

1-D. MINORS RECEIVING TREATMENT:

- The parent/guardian(s) is responsible for payment at the time of service. We will not bill parents or others for a minor's session.
- No minor can be treated without signed consent of a parent or guardian.
- Unaccompanied minors will be denied services (except in the case of an emergency). Parent/guardian must be in the office while minor is being treated. Children 16 or 17 may be an exception with notice to the counselor in advance.
- Parents are expected to be involved with treatment of a minor. If a parent or guardian is unwilling or unable to participate, parent must consult with therapist before minor begins treatment. (Note: Additional fees may apply)

Disclosures: Please Read Each Item Listed Below And Initial Each Indicating Agreement:

- I agree to conduct myself in an appropriate manner. Small children must be attended at all times.
- **Confidentiality:** I understand that no information about me or my issues will be disclosed to anyone outside of the Counseling center. However, for the purposes of supervision, billing, and training, *some* information may be shared with other staff. I will maintain the confidentiality of anyone I see in the counseling office or in my group.
- **Limits of confidentiality:** I understand that physical abuse, sexual abuse, neglect, of children (under 18 years of age) or endangerment through the witnessing of domestic violence must be reported by law. I understand that physical abuse, sexual abuse, or neglect of the elderly (65 years and older) or disabled must be reported by law. I understand that intent to



do harm to another person will be reported to that person and the police. ELCCC does not guarantee that other counseling clients or family members will maintain confidentiality.

— **HIV/AIDS CONFIDENTIALITY STATEMENT**

ELCCC does NOT perform HIV/AIDS testing. ELCCC does everything within its reasonable power to follow the Georgia Laws regarding the disclosure or non-disclosure of HIV/AIDS. This includes:

If a client discloses their HIV/AIDS status to ELCCC personnel, ELCCC personnel or contractors will not, pursuant to Georgia legal code, knowingly or intentionally disclose that information to another person or legal entity, nor can they be compelled by subpoena, court order, or other judicial process to disclose that information.

However, HIV/AIDS confidential information may be disclosed to the person identified by that information or, if that person is a minor or incompetent person, to that person's parent or legal guardian.

In addition, HIV/AIDS confidential information may be disclosed to any person or legal entity designated to receive that information when that designation is made in writing by the person identified by that information or, if that person is a minor or incompetent person, by that person's parent or legal guardian.

HIV/AIDS confidential information may be disclosed to any agency or department of the federal government, this state, or any political subdivision of this state if that information is authorized or required by law to be reported to that agency or department.

In addition, if any ELCCC employee, contractor, or staff member reasonably believes that another employee, contractor, or staff member, the spouse or sexual partner or any child of the client, spouse, or sexual partner is a person at risk of being infected with HIV by that client, the employee, contractor, or staff member may disclose to that employee, contractor, or staff member, spouse, sexual partner, or child that the client has been determined to be infected with HIV, after first attempting to notify the client that such disclosure is going to be made.



Limits of the Therapy Relationship and Social Media

Psychotherapy is a professional service and it must be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a “dual relationship,” which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

Counseling Relationships

Dual relationships like these are improper:

- I cannot be your supervisor, teacher, or evaluator. I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts. I cannot provide therapy to people I used to know socially, or to former business contacts. I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you or trade or barter your services (things like tutoring, repairs, child care, etc.) or goods for therapy. I cannot give legal, medical, financial, or any other type of professional advice. I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

Phone

Phone conversations are limited to 10-15 minutes and will be primarily for scheduling changes and notifications only, unless we agree upon TeleMental Health Counseling. You can contact me by leaving a voicemail message on my confidential voicemail and I will return the call within 12 hours. TeleMental Health counseling is available.

Location-Based Services

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location.

Valant Electronic Portal

ELCCC uses an electronic health system portal. You will receive an invitation in your email to join the portal. Communication with your counselor can be done directly through the portal. You may send confidential information, complete assessments, and receive invoices through the portal which is HIPAA compliant. Your information will be entered into the electronic record and all information will be stored in a HIPAA compliant fashion. Your information WILL NOT be available to anyone but your counselor and our office staff. If you are not using insurance, your information WILL NOT be available to the insurance company.

I would like to receive notification reminders of my appointment 48 hours in advance so that I may comply with Eagles Landing’s policy for missed appointments and avoid a \$65 missed appointment fee. Check all that apply and provide current contact information and circle your preference:

I prefer: Telephone Number: _____ Electronic Voice Text

Email _____

Friending & Following

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship. I will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines

It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If I have reason to suspect you are a danger to yourself or others and I have exhausted all other reasonable means to contact you and/or your emergency contact, then I may use a search engine for information to ensure your welfare. If this ever occurs, I will fully document the search and discuss it with you at your next session

Counselor’s Quiet Hours & Vacation (to be completed by your individual counselor in session)

Counselors are not available between 9pm and 9am or on weekends.



During these hours, please refer to the Crisis Needs section. If you need to cancel your appointment, please call my cell phone during my work hours and leave a message. Remember that I prefer cancellations 48 hours in advance, and need to be more than 48 hours before your scheduled appointment or you will be charged the full fee.

Crisis Needs

In the event that you are having urgent suicidal thoughts, or need hospitalization, please go to the nearest emergency room or dial 911. You may also call the Georgia Crisis and Access Line, which can be reached at **800.715.4225** and **404.527.6700**. For urgent needs you may contact me at my after-hours number on my business card or by calling the office at **678-289-6981**. I will return your phone call as soon as I possibly can, but am frequently in session throughout the day. I will provide you with another counselor's name whom you may contact while I am away on vacation.

Counseling Contract:

I acknowledge that I have received, have read (or have had read to me), and understand the "Informed Consent" and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward 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 to 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 the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

My signature below shows that I understand and agree with all of these statements.

Signature of Patient _____ Date _____

I, the therapist, have discussed the issues above with the patient. 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.

Signature of therapist _____ Date _____

Copy accepted by patient

Copy kept by therapist

This is a strictly confidential patient medical record. Rediscovery or transfer is expressly prohibited by law.



Insurance Certification and Approval Form
(Complete if you are using insurance other than Medicaid)

Patient Name: _____, _____, _____ Date of Birth: ____/____/____
Last MI First

Street Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Name of insured: _____, _____, _____ Date of Birth: ____/____/____
Last MI First

Relationship to patient: self wife husbandparent child

Street Address: _____ City: _____ State: _____ Zip: _____

Name of PRIMARY Insurance Company: _____ Do you have a second insurance? _____

ID on PRIMARY card: _____ Group ID: _____

Billing address for insurance company: Street Address: _____

City: _____ State: _____ Zip: _____

Telephone number on back of card for customer service or billing: _____

Name of SECONDARY Insurance Company: _____ NONE

ID SECONDARY on card: _____ Group ID: _____

Billing address for insurance company: Street Address: _____

City: _____ State: _____ Zip: _____

Telephone number on back of card for customer service or billing: _____

Request/Informed Consent to bill Insurance or Third Party Payers

By signing below, I request that Eagle's Landing Christian Counseling Center, Inc. to submit a claim to my health insurance for mental health counseling sessions.

I also understand that, in order to submit this claim to my insurance company that I will be given a provisional mental health diagnosis which may be along the lines of depression or anxiety disorder, according to the current symptoms I am experiencing.

In addition, I understand that the impact of this diagnosis appearing on my personal health record could, among other things, endanger my ability to purchase Life and/or Health Insurance in the future. I understand there could be other negative outcomes not mentioned in this Informed Consent and not foreseen by either my Individual counselor or ELCCC, Inc.

I agree to not hold ELCCC Inc. or my individual counselor responsible for any future ramifications of having been given a diagnosis for the purpose of mental health treatment.

In addition, I understand I am responsible to pay all co-pays and deductibles as required by my insurance company at the time of service. I understand that my co-pays cannot be waived for any reason.

Name: _____ Signature: _____ Date: _____



Waiver of Medicare, Medicaid or other insurance Benefits/Agreement for Fee for Service

Please read and choose the paragraph that applies to you.

- I am signing this form due to my decision to participate in outpatient psychotherapy. I understand that my provider is NOT a Medicare or Medicaid provider and therefore cannot bill Medicare or Medicaid for services I am requesting. I also understand I am free to seek such services from a Medicare or Medicaid provider now and in the future, but am choosing not to do so at this time.
- I am signing this form due to my decision to participate in outpatient psychotherapy. I understand that my provider is NOT enrolled as a provider for my insurance company and that ELCCC will not be billing my insurance on my behalf. I may receive a receipt that I can submit to my insurance company for possible reimbursement, but ELCCC does not guarantee or promise any such reimbursement. I also understand I am free to seek such services from an enrolled provider now and in the future, but am choosing not to do so at this time.
- I am signing this form due to my decision to participate in outpatient psychotherapy. I understand that my provider IS enrolled as a provider for my insurance company but I am choosing NOT to use my insurance at this time and will pay the fee for service. I understand that this means the office will NOT be billing my insurance for the cost of my sessions and I will be fully responsible for any and all fees. I understand that I am free to change my mind but must sign a different insurance contract if I do. I must give my counselor and the office a 7-day notice, provide my insurance information, and pay the appropriate co-pay upon arrival. I understand that the office cannot go back and bill past sessions to the insurance company but I am free to submit my receipts to the insurance company for reimbursement along with a copy of this letter showing my choice to opt-out of insurance initially. By signing this form, I hereby agree that I am aware I will be personally financially responsible for the therapy. I also understand and agree that I am entering a fee-for-service and am accountable for payment of psycho-therapeutic services at the time they are received. I agree that I will notify my provider immediately should I enroll in another insurance plan as this would possibly invalidate this voluntary agreement.

Name: _____ Date of Birth: _____

Patient/Client Signature: _____ Date: _____