**Client Information**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer and/or School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your phone numbers and indicate whether messages are allowed to be left at this number.

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes No

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insured Information**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pre-certification number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Person**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acceptance or Refusal of HIPAA laws (Patient’s Bill of Rights).**

I acknowledge the receipt of patient privacy policy.

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I decline receipt of patient privacy policy.

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment**

Brianne Reed is a Licensed Marital and Family Therapist (LMFT) and Licensed Alcohol and Drug Counselor (LADC) with experience treating individuals, couples and families. She has worked in outpatient and inpatient settings treating mental health and substance abuse diagnoses. She provides treatment for depression, anxiety, adjustment to stress, trauma, marital and relational conflict, substance addiction and parenting struggles.

A. **Fees for Service and Evaluation:**

Fees for Evaluation and Therapy:

$135 for a 50-minute individual, couple or family session

$35 per telephone consult block (blocks are 1-15 minutes in length)

$200/hr. for court reports or court-related work (including drive time)

$45 for letters (court, probation officer, etc.)

B. **Special Services and Fees:**

Phone calls are accepted to schedule/reschedule appointments and for telephone consults. All phone call discussions outside of scheduling will be considered a telephone consult. Please know that telephone consults must be scheduled in advance and are subject to our availability. Telephone consults are not reimbursed by insurance; therefore, you will be responsible for the above stated fee.

Letters are often required for outside entities. One attendance letter will be provided free of charge. If additional letters or reports are needed, there will be a fee. Please give at least 7 days’ notice so the letter can be prepared with the care needed.

Notice of fee increases will be given before the increase goes into effect.

If any property is damaged while on the premises, you will be responsible for cleaning, repairing or replacing the damaged property.

We are not child-custody evaluators and are not qualified to make determinations in divorce or custody matters. We can, however, refer you to one of these providers if needed.

If your child is subject to a child custody agreement, you will need to provide a copy of it to Reed Counseling Services prior to the minor being seen.

**INITIALS \_\_\_\_\_\_\_\_\_\_\_ By initialing here, you agree to the above stated fees and special services.**

C. **Cancellation Policy**

If you cannot make it to a session, a 24-hr notice **must** be given to avoid a late cancellation fee. A late cancellation fee is the price of the scheduled session and will be charged **at the time** of the missed session with the credit card on file (including the transaction fee). \*\*If your session is Monday, please provide your cancellation notice by Friday at 3p.m. to allow proper time to fill the appointment slot. Cancellations done on Saturday and Sunday will be subject to the late cancellation fee.

If you are late for a session, the session will still end at the designated time and you will be required to pay for the full session. I will not bill insurance for any sessions that start over 15 minutes late, and this will be considered a private pay session. If you are more than 20 minutes late, the session will not be held and you will be charged the late cancellation fee.

If you are in couple’s therapy, unless we have planned otherwise, both partners must be present. Children are not allowed in the therapy session, unless we have planned for a family session. Children are not allowed to be left unattended in the waiting room. Child care must be arranged prior to a session or a session must be canceled.

If you cancel or miss two or more sessions in a month, you will only be allowed to schedule a same-day session. If you miss that session, your file will be closed and you will receive a referral to another provider.

D. **Payment, Insurance and Self-Pay**

Payment is due at time of service. We prefer cash or check payment methods. Checks are to be made out to *Reed Counseling Services*. There is a $30 fee for returned checks. For your convenience, credit cards are accepted with a transaction fee of 4%.

We can file HealthChoice insurance, however, you must ensure you have mental health benefits. You will be responsible for any remaining balance. An itemized receipt can be provided upon request to allow you to file claims with out-of-network insurance providers or other sources. We assume no responsibility for your reimbursement from these sources.

If you discontinue services, any balance on your account is due immediately. We will charge the credit card left on file including the transaction fee. If the credit card on file is declined, a late fee of $40 will be applied to the account. An additional late fee will be added every 30 days. After 90 days past due, the account will be sent for recoupment via collections and/or legal means. At this point, we will stop charging the late fee, but an automatic 35% of the balance (including late fees) would be added to cover the costs of recoupment.

**INITIALS \_\_\_\_\_\_\_\_\_\_ By initialing here, you agree to the above stated cancellation, payment, and collection policies.**

E. **Appointment Hours/Late appointments:**

Our normal hours of operation are Tuesday through Thursday from 8 am to 5 pm. If you call, email, or text outside of these hours, please be aware responses may be delayed until the next working day. Scheduling related messages will be answered outside of business hours when we are able to do so.

F. **Confidentiality**

We take your confidentiality very seriously. In keeping with state law and the Ethics of Counseling, confidentiality will be maintained at all times with these exceptions:

1. If there is suspected child, elder, or dependent adult abuse, or harm to self.
2. Situations in which a serious threat to a well-identified victim is communicated to the therapist.
3. If you are required to sign a release for information by your medical insurance or you are involved in litigation or other matters with private or public agencies.
4. Persons being seen in a couple, family or group modalities are legally obligated to respect the confidentiality of others. Your therapist will exercise discretion (but cannot promise absolute confidentiality) when discussing private information to other participants in your treatment process.
5. At times, I may seek consultation with professional colleagues about our work without seeking permission, but your identity will not be disclosed.
6. Children under the age of 18 do not have full confidentiality from their parents.
7. In certain extreme and rare cases, the court can subpoena therapy records.

In addition to the above exceptions, for couple’s and family therapy, our therapists maintain a “no secrets policy”. If you and/or your partner decide to do individual sessions as part of couples’ therapy, what is said during these individual sessions may be discussed in the couples’ session based on my professional judgment. If you have more questions about this policy, please ask.

**INITIALS \_\_\_\_\_\_\_\_\_\_ By initialing here, you agree to the above stated appointment and confidentiality policies.**

G. **Communication Forms**

Text messaging and emailing are not HIPAA compliant forms of communication; therefore, we cannot guarantee confidentiality. Use of text messages and emails is at your own risk. If you do choose to text or email, please keep the information to 1) scheduling and rescheduling of appointments and/or 2) brief information associated with client/child behaviors, symptoms or medication changes.

**INITIALS \_\_\_\_\_\_\_\_\_\_ By initialing here, you agree to the above stated text message/email policy. You also agree to hold Reed Counseling Services and its employees harmless from any breaches of confidentiality resulting from your transmittal of protected healthcare information via unsecure means (such as via text message or email).**

**Emergency Services**

If there is an urgent need to talk to us, please call the number provided. Your call will be returned as soon as possible, but we do not offer emergency service. If we are unable to return your call, please call: 911 or go to the emergency room of the nearest hospital.

**\*I have read this form, agreed to the terms of consent and understand the limits and conditions of therapy. I agree to the financial consideration and appointment policy. I also allow my limited information to be released for the purpose of payment only to insurance companies and payers other than myself. My signature affirms my informed and voluntary consent to receive therapy in full accordance with the terms set forth herein.**

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form**

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CVV #\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please **initial** next to **all** of the authorized charges below:

\_\_\_\_Session Fee and/or Phone Consultation Fee

\_\_\_\_ Missed Appointment Fee (late cancel and no show)

\_\_\_\_Remaining Balance

\_\_\_\_Credit Card Transaction Fee

\*By signing this credit card authorization form, you authorize Reed Counseling Services to bill your credit card when necessary for the charges listed above. A transaction fee of 4% of the balance will be added in order to cover processing fees. This form will be stored in accordance with HIPAA guidelines. It will not be stored electronically and will be destroyed upon termination and balance closed.

Payments are due at the time of service. The credit card that you provide will be charged for any remaining balance upon termination or past due notice.

|  |  |
| --- | --- |
| Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_ |