

RER Counseling Services, PLLC
Rebekah Robison, M.S., LADC
3917 E Memorial Rd Suite A
Edmond, OK 73013
(405) 596-8401

Client Information

Full Name: _____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Last 4 digits SSN: _____

Employer and/or School: _____ Grade: _____

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

Other Phone: _____ Yes No Cell Phone: _____ Yes No

Email: _____

Parent/Guardian's Name: _____ Phone number: _____

Referred by: _____

Reason for seeking services: _____

Emergency Contact Person

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Consent

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: _____

Guardian: _____ Date: _____



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Consent for Treatment

Rebekah Robison has a masters degree in Marriage & Family Therapy and is a 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:

\$165 for a 45-50-minute individual, couple, and/or family session

\$50 per telephone consult block (blocks are 1-15 minutes in length)

\$250 for drug and alcohol assessments

\$300/hr. for court reports or court-related work (including drive time)

or **\$2000/day** for full court appearance - due up front

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 RER Counseling Services, PLLC prior to the minor being seen.

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



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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 full price of the scheduled session and will be charged **at the time** of the missed session with the credit card on file. ****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. If you are more than 15 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. Childcare 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, and payment of no-show fees will be required prior to the 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 *RER Counseling Services, PLLC*. There is a **\$30** fee for returned checks. For your convenience, credit cards are also accepted. A credit card authorization form is attached if that is your preferred method of payment. If completed, your credit card will be kept on file and charged after your sessions.

We do not file with insurance for any provided services. 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. 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.*



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E. Appointment Hours:

Our normal hours of operation are **Tuesday through Friday from 9:30am to 5:00pm** with late appointments available on Tuesday and Thursday. 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. Please be aware that we are often in session and unavailable to answer the phone on a regular basis. If there is an emergency please call 911 or go to your nearest emergency room. There is also a QR code in the footer of the paperwork that can be used for online scheduling.

F. Confidentiality:

We take your confidentiality very seriously. In keeping with state law, HIPPA and the Ethics of Counseling, confidentiality will be always maintained 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.*



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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 scheduling and rescheduling of appointments and/or 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 RER Counseling Services, PLLC 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).

H. 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: _____

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

I acknowledge and **accept** the receipt of patient privacy policy.

Client: _____ Date: _____

Client: _____ Date: _____

Guardian: _____ Date: _____



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I **decline** receipt of patient privacy policy.

Client: _____ Date: _____

Client: _____ Date: _____

Guardian: _____ Date: _____

Background and Information

My name is Rebekah M. Robison, and I am originally from Edmond, Oklahoma. I was homeschooled until high school and was an active member of Henderson Hills Baptist Church growing up. I obtained two degrees from Oklahoma State University, a bachelor's in Human Development and Family Sciences and a master's in Marriage and Family Therapy. I also hold a state license in Alcohol and Drug Counseling. In 2010 I graduated with my master's degree and began work at a residential treatment center for women and their dependent children, Jordan's Crossing, where I quickly moved into a leadership role. Most recently I was the Clinical Director at an agency in Guthrie, Logan Community Services, where I worked for over six years; carrying my own caseload, overseeing school, court, DHS, and several other state-funded programs. While there I also supervised other clinicians as well as a handful of interns and managed the agency's Department of Mental Health & Substance Abuse (ODMHSAS) contracts. At the beginning of 2020 I decided to make the leap into private practice and joined New Path 12:2 as a self-employed clinician.

I primarily provide talk-therapy in the form of Cognitive Behavioral Therapy to clients of all age groups and have training in child play therapy, trauma-focused CBT, Parent-Child Interaction Therapy (PCIT), and parent management training. I believe in process-level homework with my clients because I do not think growth should be limited to the therapy office but should be a continual process throughout the week. Your initial sessions will be mainly focused on assessment as I get to know you and provide context to your current situation. We will then move to more process-level sessions where we dig into problems and move towards resolution. I believe therapy is a collaborative process and want to work with you to achieve your goals. If at any point you believe we are not going in the direction you had hoped, or we are not touching on something important, please let me know.

I am excited you have reached out to me and look forward to coming alongside you in this process.



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Credit Card Authorization Form

Name on Credit Card: _____

Type of Card: _____

Account Number: _____

Expiration Date: _____ CVV # _____

If different from intake information:

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

***If a credit card is your preferred method of payment, please complete this form. Your credit card will then be billed at the end of each session.**

*By signing this credit card authorization form, you authorize RER Counseling Services, PLLC to bill your credit card when necessary for the charges listed above. 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: _____



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“NO SURPRISES ACT” GOOD FAITH ESTIMATE FORM

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Provider: Rebekah Robison License #: LADC 1102

Provider Address: 3917 East Memorial Road Ste. A

Provider Phone #: (405) 596-8401 Provider NPI #: 1568767978

Primary Diagnosis and Diagnosis Code: _____

Services Requested: _____

Date of Initial Session (if applicable): _____

You are entitled to receive this Good Faith Estimate of what the charges could be for psychotherapy services provided to you. While it is not possible for your therapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person(s), this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service.

This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charges). You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial



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assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute resolution process, visit <https://www.cms.gov/nosurprises/consumers> or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

I anticipate your treatment will require weekly 45-50-minute psychotherapy sessions throughout the next 12 months at \$165 per session for a total of 50 weeks taking into consideration availability for an estimated total of [\$165] x [50]. Based upon a fee of \$165 per visit, if you attend one (psychotherapy) session per week, your estimated charge would be \$ \$8,250.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Client Name

Client Signature

Therapist

Date

