

Associate Counseling Center, Inc.

PATIENT INFORMATION

Name: _____ SS#: _____
First Middle Last

Address: _____
Street City State ZIP

Phone: _____ Marital Status: _____ Birth Date: _____

Employer: _____ Phone: _____

Gender M F (circle one)

Primary Card Holder (if other than client)

Name: _____ SS#: _____
First Middle Last

Address: _____
Street City State ZIP

Relationship to Client: _____ Phone: _____

Employer: _____ Phone: _____

Birth Date _____ **Gender M F** (circle one)

INSURANCE INFORMATION – please show all insurance cards to receptionist.

Primary Insurance Carrier: _____ we
do not file secondary insurances

I hereby authorize Associate Counseling Center, Inc. to release to my insurance company or its representative, any information regarding my treatment, including diagnosis, necessary to process my insurance claim.

I hereby assign all my rights to benefits payable by my insurance company to Associate Counseling Center, Inc. and thereby authorize and request my insurance company to pay my benefits directly to Associate Counseling Center, Inc..

All insurance information has been listed correctly. I understand that if I have any other health insurance coverage, including an HMO that is not listed above, any charges not covered by the listed insurance will be my responsibility. I understand that **if I fail to cancel an appointment 48 hours before appointment that I will be responsible for the full session charge.** I also understand that I am responsible for payment regardless of insurance arrangements in the event insurance payment is not obtainable. I give ACC permission to bill and or contact me for payment issues by mail or voicemail.

I have read, understood and signed the receipt of and a copy of the Patient Handbook and
Outpatient Agreement dated 9/15/09 (see later in paperwork)

I agree to tell my counselor if I have thoughts of harming myself or others.

Signature

Date

Primary Care Physician: _____ Phone: _____
Address: _____
Current Health Problems: _____
Medications Prescribed: _____ Date of Last Visit: _____

Emergency Contact: Name: _____
Address: _____
Relationship to Client: _____ Phone: _____

Counseling History: Previous Psychiatric or Psychological Services: ___ Yes ___ No
Treatment Provider: _____ Phone: _____
Address: _____
Reason for seeking care: _____
Treatment outcome: _____

Treatment Provider: _____ Phone: _____
Address: _____
Reason for seeking care: _____
Treatment outcome: _____

Please circle any of the following problems that pertain to you:

- Nervousness Depression Fears
- Shyness Sexual Problems Suicidal Thoughts
- Separation Divorce Finances
- Drug Use Alcohol Use Friends
- Anger Self-Control Unhappiness
- Sleep Stress Work
- Relaxation Headaches Tiredness
- Legal Matters Memory Ambition
- Energy Insomnia Making Decisions
- Loneliness Inferiority Feelings Insomnia
- Education Career Choices Health Problems
- Temper Nightmares Marriage
- Children Appetite Stomach Trouble
- Bowel Troubles Being a Parent My Thoughts

Additional reasons for seeking care: _____

List the members of your family and all others in your home:

Name	Age/Birth Date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Name: _____ Today's Date: _____

Age: _____ Sex: _____ Birth Date: _____ Birth Place: _____

Where did you grow up: _____

Current Marital Status: _____ Married _____ Widowed _____ Separated _____ Single (Never married) _____ Divorced
_____ Unmarried Couple

List your children in birth order and give their current ages:

COUNSELING HISTORY:

Have you had any prior counseling? No Yes If yes, please describe.

List any support groups you attend. _____

Is there a family history of (Circle all that apply) Alcoholism Substance Abuse Mental Illness

Has anyone in your family been treated for a psychiatric disorder? No Yes If yes, please explain:

DRUG/ALCOHOL HISTORY:

Have you ever used alcohol and/or drugs to change or alter your behavior or mood? No Yes

If yes, please explain _____

Have you ever been charged with DWI/DUI? No Yes. If yes, please explain.

Complete the following for family members who use or have a history of alcohol/drug abuse

Family Member	Chemical Used	Current Use (Y/N)	Received Treatment
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PHYSICAL HEALTH:

General Status of Health: Emotional _____ Physical _____

Height: _____ Weight: _____ Physician: _____

When was the last time you had a physical examination? _____

Are you presently taking any medications? No Yes If yes, list medications and dosages & reason.

Do you suffer with allergies? No Yes If yes, please explain

Sleep patterns (Past two weeks) _____ No problems _____ Nightmares _____ Insomnia

Early morning waking _____ Difficulty falling asleep _____ Restless

Is this pattern Typical or Unusual? (Circle one)

Daily eating habits (Past two weeks) _____ 1-2 meals _____ 2-3 meals _____ snacks

Is this pattern Typical or Unusual? (Circle one)

Do you have or have you ever had any eating disorders? No Yes

If yes, please explain. _____

Please describe any past or current sexual problems.

Do you presently experience emotions and/or moods severe enough to affect your day to day functioning?
(Circle one) Never Seldom Often (6 times a year)

Circle all that apply: Anxiety Frustration Manic states Depression Anger Confusion

FAMILY HISTORY

FATHER: Nationality _____ Highest Level of Education _____

Occupation: _____

Describe your relationship: _____

MOTHER: Nationality _____ Highest Level of Education _____

General Status of Health: Emotional _____ Physical _____

Occupation: _____

Describe your relationship: _____

With whom did you live during your childhood? _____

List brothers and sisters (including yourself) in birth order and give their current ages:

Describe your childhood: Happy Unhappy Mixed

Please explain: _____

Describe your adolescence: Happy Unhappy Mixed

Please explain: _____

Were you abused? No Yes (Circle all that apply)

Physically emotionally verbally sexually

EDUCATIONAL HISTORY

Indicate your highest level of education: _____

Number of years completed _____ GPA: _____

Describe any specialized skills for which you have training, certification or licensure:

VOCATIONAL STATUS

Describe your employment history for the past five years beginning with your current position:

Employer Position Time in Job Reason for leaving

Describe any physical/emotional problems that prevent your being employed:

JOB PERFORMANCE

Has your employer or supervisor ever expressed any of the following concerns to you? (Circle all that apply)

Missing too much work/ Assigned tasks not completed / Irresponsibility / Poor/bad attitude / Difficulty getting along with others / Late too often / Attitude/behavior change / Difficulty getting along with supervisors / Increased errors

MILITARY HISTORY

Have you ever served in the military service? No Yes Which branch _____

Age at enlistment: ____ Rank at discharge: _____

Did you ever serve in combat? No Yes

If yes, please describe:

LEGAL HISTORY

Do you have any legal action now pending? No Yes If yes, please explain.

Are you currently on probation and/or parole? No Yes If yes, please describe.

LEISURE, RECREATIONAL INTERESTS & HOBBIES

Would you consider your life as (Circle Yes/No for each option)

Work oriented Yes No / Family oriented Yes No / Self oriented Yes No / People oriented Yes No / Leisure oriented Yes No
Recreation oriented Yes No

Activities you enjoy by yourself: _____

Activities you enjoy with your family: _____

Activities you enjoy with your friends: _____

Do you exercise on a weekly basis? No Yes

How often weekly? (Circle one) 1-2 times 3-4 times 5+ times

Do you have physical limitations that prevent exercise or physical activity? No Yes

If yes, what are they? _____

Are you able to separate drug and/or alcohol use from your activities? No Yes Sometimes

SPIRITUAL HISTORY

Although not required, the following questions would contribute to your therapist's understanding of you as a spiritual person., It is not our intent to impose our doctrinal perspective but to acknowledge that counseling is not value-free and to be sensitive to your beliefs. Feel free to discuss any questions with your therapist.

1. While growing up, did you have a religious affiliation? If so, what and how important a part of family life was it?

2. Do you have any current religious affiliation? If so, briefly describe your present involvement.

3. Are spiritual issues or resources important to you in therapy? If so, briefly describe.

4. I would describe God as . . .

5. I think God see me as . . .

6. Where are you with God right now?

7. The most positive religious experience I have had is . . .

8. The most negative religious experience I have had is . . .

9. Has there been a significant change in your spiritual life or perceptions within the past year? If so, please describe briefly.

10. Please add additional information or comments that you feel might have significance in this area.

Associate Counseling Center, Inc.
380 Maple Ave. West
Suite 304
Vienna, Va. 22130

In accordance with the HIPPA Privacy Rule, we may not leave a message at your home without your consent. This will mean that we may no longer confirm your appointments or contact you for a cancellation by leaving a message for you with someone else or on an answering machine.

Please initial the following statement that will pertain to you.

- ____ 1. You may contact me to confirm my appointments or notify me of cancellations by leaving a message.
- ____ 2. You may not leave me a message to confirm my appointments or notify me of a cancellation. By leaving a message. I will be responsible for remembering my scheduled appointments.

Please keep in mind the full fee is charged for missed appointments or cancelled less than 48 hours in advance or for not showing up at all.

Signature

Date

Name Printed

Appointment Confirmation Agreement

Associate Counseling Center, Inc.
380 Maple Ave. West
Suite 304
Vienna, Va. 22180

I, _____ acknowledge receipt of the Associate Counseling Center (ACC) Patient Handbook and Outpatient Agreement (dated 9/15/09) on the occasion of my first appointment (see proceeding pages) with ACC staff for services on this date, _____. I further acknowledge that I have read and understand the contents of the Patient Handbook, including the Notice Form, and Outpatient Agreement (dated 9/15/9) and hereby give Informed Consent to treatment. I understand that Protected Health Information (PHI) held by ACC for the purpose of providing requested services to me will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI. This agreement indicates my commitment to enter into treatment, and my understanding of the basic ideas, goals, and methods of this therapy. I consent to keep my therapist up to date about any changes in my symptoms or situation that may impact the success of treatment. I understand that as we evaluate progress periodically, these goals may change and new goals may be agreed upon to serve my long-term best interest. I realize that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. My relationships with significant others may also undergo substantial change during the course of treatment. I understand that if I elect to terminate treatment, **I agree to schedule a closing session with my therapist** to discuss my progress, outcomes of treatment, and any further clinical recommendations. I also understand that the staff at ACC can use my information for supervision.

Signature of Client or Guardian Date

Receipt of Patient Handbook

VIRGINIA NOTICE FORM CLIENTS COPY – Please Keep

Notice of Counselors' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Associate Counseling Center, Inc. (hereafter known as ACC) its clinicians, staff and authorized personnel may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - Treatment is when ACC provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when ACC personnel consult with another health care provider, such as your family physician or another psychologist.
 - Health Care Operations are activities that relate to the performance and operation of the ACC practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within ACC, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of ACC, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

ACC may use or disclose PHI for purposes outside of treatment, supervision, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when ACC is asked for information for purposes outside of treatment, supervision, payment and health care operations, ACC will obtain an authorization from you before releasing this information. ACC will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes ACC clinicians have made about our conversation during a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI. If you request in writing at the first session that your PHI and psychotherapy notes be kept in separate files, ACC will maintain them in a separate file.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

III. Uses and Disclosures with Neither Consent nor Authorization

ACC may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If ACC clinicians have reason to suspect that a child is abused or neglected, they are required by law to report the matter immediately to the Virginia Department of Social Services.

Adult and Domestic Abuse: If ACC clinicians have reason to suspect that an adult is abused, neglected or exploited, they are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

Health Oversight: The Virginia Board of Counseling has the power, when necessary, to subpoena relevant records should ACC be the focus of an inquiry.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and ACC will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, you can move to quash (block) the subpoena

Serious Threat to Health or Safety: If ACC is engaged in professional duties and you communicate to a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and the ACC clinician believes you have the intent and ability to carry out that threat immediately or imminently, they must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer. If you communicate that a family or friend has informed you that they are planning to do harm to themselves or others, and ACC believes they have the motive, intent and means to perform such an act that ACC will take appropriate action to protect those at harm.

Worker's Compensation: If you file a worker's compensation claim, ACC is required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Supervision from ACC staff or other supervisor. There will be an attempt to conceal all identifying information not necessary for supervision.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

- Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, ACC is not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a clinician at ACC. Upon your request, ACC will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in ACC mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. ACC may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, ACC staff will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. ACC may deny your request. On your request, ACC staff will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, ACC staff will discuss with you the details of the accounting process.

- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from ACC upon request, even if you have agreed to receive the notice electronically. A written request is required.

Counselor’s Duties:

- ACC is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- ACC reserves the right to change the privacy policies and practices described in this notice. Unless ACC notifies you of such changes, however, ACC is required to abide by the terms currently in effect.
- If ACC revises its policies and procedures, ACC will provide all current patients with a written copy of the revision to its policies and procedures at the time of your next appointment after the revisions are made, or by U.S. mail in the event that you are not available for receipt of the revisions in office.

V. Complaints

If you are concerned that ACC has violated your privacy rights, or you disagree with a decision ACC has made about access to your records, you may contact John Raymond, ACC Privacy Officer, at 703-999-5567.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 9/15/09. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by the time of your next appointment after the revisions are made, or by U.S. mail in the event that you are not available for receipt of the revisions in office. REVISED 07/05/2006 – 9/15/2009

OUTPATIENT SERVICES CONTRACT

Welcome to Associate Counseling Center. This document contains important information about my professional services and business policies. **Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting.** When you sign the receipt of this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Nevertheless, there are no guarantees of what you will experience and at times, you may reevaluate your current relationships.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.]

PROFESSIONAL FEES

My hourly fee is \$125 for intake, \$115 for family/couple, \$115 Individual w/o identified client, \$100 individual, and \$25 to \$45 for group. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge \$100 per hour for preparation and attendance at any legal proceeding.]

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. In addition, your premiums may be affected by an insurance claim. I will provide you with a copy of any report I submit, if you request it in writing.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by an answering service - machine, or voice mail - that I monitor frequently.. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times

when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist /psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records (by written request only) unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. A written review from me is an option you may take. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. I may also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. [At the end of your treatment, I may prepare a summary of our work together for your parents, and we will discuss it before I send it to them.]

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Associate Counseling Center, Inc.

CASH PAYMENT AGREEMENT

We are fully committed to helping you accomplish the goals you establish when you enter counseling, to help you maximize your investment of time and finances. We will deal with you fairly, equitably and with sensitivity in financial matters. We believe that a clear understanding of our financial policies is important for both client and therapist. The following information is presented with this in mind. A copy for your records will be provided upon request.

PATIENT NAME: _____

RESPONSIBLE PARTY _____

NORMAL FEES

- Intake - \$125 / 50 minute session
- Individual - \$100 / 50 minute session
- Family - \$115 / 50 minute session
- Family without client - \$115 / 50 minute session
- Groups - \$25 to \$45 (depending on group)

We can adjust our fees for those who do not have insurance as a courtesy to our patients.

PAYMENT MUST BE PAID BEFORE BEING SEEN UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

I agree to make prompt arrangements to pay for my total outstanding balance. I agree to pay a monthly interest rate of 1.67% (APR of 20%) if my account balance is not paid in full within 30 days of the billing date. I understand that I am responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees of 40% of the balance due and any related costs of collection should such action become necessary.

To change an appointment, please phone the office at any time. If the office is closed, voicemail is available. Except in cases of true emergencies, I agree to give 48-hour notice if unable to keep an appointment. I understand that I will be **billed full payment for missed appointment** that I do not keep and for appointments canceled less than 48-hours before the scheduled time.

I understand that I am responsible for all charges incurred during the course of my treatment, including any psychological testing or other services not previously stated. I understand that after hours call, written consultations and telephone consultations of ten minutes or more will be charged at the therapist's discretion. I understand that I am responsible for any and all court cost related to my sessions.

PATIENT/GUARANTOR SIGNATURE DATE OF BIRTH

SOCIAL SECURITY NUMBER TODAY'S DATE

WITNESS _____ DATE _____

Credit Card Payment Form for Delinquent Balances

This form is authorization to charge my credit card any balance not paid after 30 days of delinquent notification.

Please Print

Client Name: First _____ Last _____

Amount: \$ _____ Date: _____

Cardholder Name: First _____ Last _____

Card Billing Address _____

Zip _____

Type Card (circle one): Visa MasterCard Discover

Credit Card # _____

Expiration Date ____ / ____ Security Code _____ (on back of card)

I agree to allow Associate Counseling Center, Inc. and or its agents or employees to process all charges for services rendered now and in the future. I understand the use of this credit card for services will create a record for charges from a counseling center, which will appear on my credit card statement.

Sign _____ Date: _____

For Office Use:

Therapist: _____