LIMITS OF CONFIDENTIALITY

Name of Patient: ________________________________

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Client Signature (Client's Parent/Guardian if under 18)

____

Today's Date

CANCELLATION AND PAYMENT POLICY

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment.
A fee of $85.00 is charged for missed appointments or no show cancellations with less than a 24 hour notice unless the missed appointment is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment within this 24 hour window.

I assure you that I enforce this policy with understanding and grace from a Christian perspective that I highly value.

Please initial that you have read and agree to this policy______.

PAYMENT POLICY

Payment is due at the time of the session unless other arrangements have been made. Your Family Matters will file your insurance claim, but you are responsible for DEDUCTIBLES, COINSURANCE, and COPAYMENTS.

It is your responsibility to familiarize yourself with insurance benefits. If you believe you have a deductible please verify this before our session so that appropriate financial arrangements can be made when we meet.

*********Unfortunately due to frequent slow payment responses our polices have changed.*********

Accounts are expected to be kept up within THIRTY (30) days.

If your account has not been paid for more than 30 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 in treatment is his/her name, the nature of services provided, and the amount due.

Please initial that you have read and agree to this policy______.

Thank you for your consideration regarding these important matters.

Name of Patient: ____

Client / Parent signature: ______________________________________

Today's date :_______/________/_______)