Turning Leaf Counseling and Consultation, LLC

Client Intake Form

Client Information: **Date:___ /____/____**

Name**:**_____

Address:_____
City/State/Zip:_____
Cell Phone:_____
Birth Date:_____
Email:_____

Other Parent Information (if client is a minor and parents are separated/divorced

Parent Name**:**_____
Address:_____ City/State/Zip:_____
Email:_____

Other Parent Information

Parent Name:_____
Address:_____ City/State/Zip:_____
Email:_____

Primary Insurance Information:

Insurance Company:_____ Insured's Employer:_____
Work Phone:_____ Plan Name:_____
Insured's ID NO:_____ Policy/Group:_____
Responsible Party: (**Circle One**) Self Parent Spouse Guardian
Guarantor for Client:_____ Guarantor's SSN:_____
Guarantor's DOB:_____ Guarantor's Cell:_____
Guarantor's Address:_____

Secondary Insurance Information:

Insurance Company:_____ Insured's Employer:_____
Plan Name:_____ Insured's ID:_____
Insured's Group:_____

Authorization to Release Information and to Pay Benefits Directly to Provider:

I authorize the release of any medical records or other information necessary to process insurance claims. I also authorize payment of benefits to be paid directly to the therapist for services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.
I understand that I am responsible to pay applicable co-payments and co-insurance amounts. Co-payments are due the day services are rendered. Service will be declined for nonpayment.
Turning Leaf Counseling and Consultation, LLC will make every effort to inform you of the cost associated with services. However, there are many factors that are beyond our knowledge or control such as your deductible, co-insurance, out of network costs, etc. Therefore, there may be additional costs above and beyond your copayment. You are advised to contact your insurance company to educate yourself on total cost of receiving services.
I understand it is my responsibility to inform Turning Leaf Counseling and Consultation, LLC if my coverage or insurance changes. I am responsible for paying for the services if insurance denies payment or if insurance has termed.
Should there be two parents who are divorced and jointly pay for counseling the respective parent who brings the child must pay the full fee and be reimbursed by the other party. Therapy will not be conducted without payment made at the time of service. .

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Financial Policy

Providers are committed to providing you with the best possible service. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about fees, the Financial Policy, or your responsibility for payment.
All clients must complete the information form and Financial Policy prior to seeing the therapist. Your insurance provider may have additional forms that they require or request.
PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, payable to **Turning Leaf Counseling** or credit card/health savings account card for payment.

Cancellations

A 24 hour notice is required for all cancellations. A fee of **$75** will be charged for the missed appointment. Insurance companies and your employee assistance programs do not pay for missed appointments. Your appointment time is reserved specifically for you. Policies regarding charging for missed appointments appear herein. Please help us serve you better by keeping your scheduled appointment. Let us know of any questions or concerns. The fee of **$75** will be charged to the credit card on file for guarantee of payment.

Insufficient Funds

I agree to pay any and all bank fees charged in the event of checks received with insufficient funds. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account and for professional services and/or consultation rendered.

Consultation

During your divorce or modification, there may be occurrences when the therapist is asked to meet with, contact or write reports or emails to the attorneys involved, specifically the guardian ad litem for the child(ren). There may be consultation fees associated with your particular case. These fees may apply to the case. Consultation with attorneys or other therapists, co-parent counselors, take us away from our practice and making time for other clients. Often, we are working late nights and weekends to meet the needs of the clients. The fee for depositions, reports, court testimony, email review/responses, phone calls, etc. As a result, there will be a minimum of four

hours charged for court or depositions. Fees for such services are paid in advance or deposited with your attorney in advance of the required date.

Professional Fees

Initial Intake	**$150.00**
Individual Psychotherapy	**$125.00**
Co-parenting ($150 initial, $100 thereafter pp)	**$150.00/$100**
No Show/Late Cancellation	**$ 75.00**
Attendance at Meetings (including travel)	**$150.00/hr**
Court Testimony/Deposition Fees (4 hour minimum)	**$200.00/hr**
After Hour Calls	**$50.00/call**
Hardship Waivers	**$500.00**
Review of emails, responses to emails, reports, calls)	**$100 (per hour)**
Copy of Medical Record	**$ 50.00**

Custody Services

Please note that if you have divorce or custody papers that require both parents to make joint decisions for medical and/or mental health issues then both parents must agree to the treatment of a minor child. Both parents must sign all consents in these circumstances. Failure to notify Turning Leaf Counseling will result in immediate discharge from services.

Client Rights and Responsibilities

I have read the client rights and responsibilities – copy with the receptionist, emailed at intake

Security of Records

Security of Records: Your treatment and related financial records are kept in a locked file cabinet. Records will not be made available to others without a signed authorization to release the information except where allowed or mandated by law. There is a charge for copies of records, which is in accordance with Missouri State Law who regulates these fees.

Security Cameras/Recordings

I agree that no camera or audio recording will be allowed in therapy sessions.

Retention of Records

- Treatment and financial records are retained for a period of 7 years following the termination of treatment for adults and until age 28 in the case of minors.
- If you have been involved in co-parenting records will not be shared without both parties agreeing.
- Special rules relating to release of treatment records containing information regarding drug and alcohol abuse include: CFR 42, Part 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is prohibited.
- If this is your desire please notify therapist upon intake or anytime during treatment. All records are destroyed in a manner that ensures complete confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

Discharging Clients

Your file may be closed for no-showing for appointments, no contact, nonpayment of fees, lack of progress, dishonesty or treatment interfering behaviors. If there is a lack of progress it will be discussed with you, and therapist can assist you with a referral to another provider.

After Hour Emergencies

Turning Leaf Counseling and Consultation, LLC is unable to provide 24/7 emergency coverage. You are welcome to attempt to call, and if therapist is available emergency services will be provided. If it is a life-threatening emergency, you will need to call 911 immediately. If it is urgent and you are unable to reach your therapist, please call the Access Crisis Intervention line at 1-888-279-8188 (open 24 hours). Business hours do vary, but typically are Monday through Friday 8am-5pm. No emergency services are provided after 5pm.

Authorization to Treat

I give consent to my therapist to provide assessment and therapeutic services to my child, within the scope of her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem as efficiently as possible. I agree to cooperate with my therapist in this treatment process and to follow through with any medical treatment, as prescribed by the treating physician.

Confidentiality of Cell phones and Email

If you choose to email your therapist from your personal email account, please limit the contents to basic issues such as scheduling and cancellations. We will not respond to personal or clinical concerns via regular email. You can email your therapist confidentially through ***TherapyAppointment***.

I have read all of the information herein. I certify that the information provided is true and correct to the best of my knowledge; and agree to notify my provider of any changes regarding the above information or other change that may impact my treatment. I agree that I have thoroughly read pages 1-4, including Authorization to Release Benefits, Financial Policy, Cancellation Policy, Insufficient Funds, Consultation, Professional Fees, Custody Services, Rights and Responsibilities, Security of Records, Cameras/Recordings, Retention of Records, Discharges, Emergencies and After Hours, Authorization to Treat and Confidentiality with Cell phone and Emails.

Signature of Client/Parent/Guardian)_____ Date:_____

Signature of Therapist:_____ Date:_____

Turning Leaf Counseling, LLC Credit Card Payment Authorization Form

By signing this form, you give permission to debit the amount for all services you have received, which may include deductible, copays, consultation, etc.

Cardholder Name:_____

Cardholder Address:_____

Account Number:_____

Expiration Date:_____

CCV (3 or 4 digits) _____

Signature:_____ Date:_____

I authorize the above-named business to charge the credit/debit card indicated on this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit/debit card company; so long as the transaction corresponds to the terms indicated in this form. I can at any time, discontinue these charges, but must do so in writing.