Peace of Mind Counseling Centers

Today's Date: _____

CLIENT INFORMATION FORM

Client's Full Name: _____ DOB: _____ SSN: _____

Age: _____ Sex: _____ Occupation: _____ Employer: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How did you hear about us? Family Friend Yellow Pages PCP Other: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE

Insurance Agency: _____ Policy #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relationship to Client: _____

☐ **I am not going to be using insurance benefits.**

For Minors Only

Biological Mother: _____ **Biological Father: _____**

Phone Number: _____ **Phone Number: _____**

Does this parent have custodial rights? Y N **Does this parent have custodial rights? Y N**

If biological parents do not have custodial rights, please list Guardian:

Name: _____ Phone Number: _____

***Please provide custodial paperwork should you wish to withhold any information from a client's parent.**

APPOINTMENT REMINDERS

Peace of Mind Counseling Centers is now providing **appointment reminders** for our clients via text or voice calls. This is not a required service for all clients, rather an option for those who wish to receive reminders. Upon completion of this form, **Peace of Mind Counseling Centers is not responsible for any breach of confidentiality from this service.**

Due to a high volume of late cancellations and no-show clients, this service will greatly benefit the productivity of Peace of Mind Counseling Centers and hopefully our clients, as well. **Since implementing this new service, we will now be enforcing our cancellation/no-show policy fee of $50 per session. However, after THREE missed sessions or late cancellations <u>for all clients, including those with Medicaid,</u> will result in termination of services.**

☐ **Yes,** I would like to receive appointment reminders by (please circle one): **Text Message** **Voice Call**

Contact Phone: _____ Contact Name: _____

☐ **No,** I do not wish to receive appointment reminders at this time.

_____

Client or Parent/Guardian Signature Date

_____

Staff Signature Date

Peace of Mind Counseling Centers

Today's Date: _____

HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____, authorize Peace of Mind Counseling Centers, PLLC to disclose and/or obtain information from the following parties (this list should include any Primary Care Physician, lawyer, school, etc., that will need to be involved/contacted in treatment):

Contact Name	Contact Number	Relationship to Client

PCP Name: _____ PCP Phone #: _____

I authorize Peace of Mind Counseling Centers, PLLC to disclose the following information to the above listed person(s):

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____Treatment Summary

_____ Current Treatment Update

_____ Testing Information

_____ Educational Information

_____ Presence/Participation in Treatment

_____ Continuing Care Plan

_____ Progress in Treatment

Other: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I understand that at any given time during treatment, I have the right to revoke this authorization, by writing, to PMCC. I further understand that revocation of this authorization is effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, I understand that this authorization will be discontinued upon termination of treatment, unless otherwise noted. I understand that PMCC will not condition my treatment upon whether I give authorization for the requested disclosure. Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information is permitted by this authorization in any manner that we deem appropriate and consistent with applicable law, including but not limited to, verbally, in paper format, or electronically.

_____

Client or Parent/Guardian Signature Date

_____

Staff Signature Date

Peace of Mind Counseling Centers

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FINANCIAL POLICY

FEE SCHEDULE:

***If using insurance for these services, fees are contingent on contracted rates with your insurance company.**

• Diagnostic & Evaluation Session (1st visit)	$250.00*
• Regular Office Visits (60 minutes)- Individuals/Couples	$225.00*
• Family Session (60 minutes)	$225.00*
• Open Path Collective Membership Rate	$50.00/hour
• Group Sessions	$50.00/hour
• Open Path Collective- Group Session	$25.00/hour
• Written Reports/Correspondence (insurance, lawyers, supervisors, pro-rated/15 min)	$100.00/hour
• Returned check fee, per check	$25.00
• No show fee or cancellation without 24-hour notice	$50.00

Requests for records (in accordance with standards set by the Arkansas Medical Board, we will be charging the following for all medical record releases):

- $15.00 labor fee on all records
- $0.50 per page for the first 25 pages, then $0.25 thereafter
- All postage related to the notes
- $50.00 rush fee for anyone wanting less than our standard 5-10 business days minimum

PAYMENT/INSURANCE FILING: Payment of fees is required at the beginning of each session. If payment is not received before session, the card on file will be charged our no-show fee listed above. We will provide a statement of services rendered upon request. Please note that if we bill your insurance, you will be responsible for providing the therapist with the necessary information and we will help you file the claim with your insurance. Also note that if your insurance will not cover services provided, that you are responsible for making sure payment is received in full, per the fee schedule above. If necessary, reasonable payment arrangements can be made with the office administrator before the date of service. Clients are held financially responsible for payment of a therapy session once an appointment is scheduled unless at least 24 hours advance notice of cancellation was provided. If the balance of the account is unpaid 60 days after the scheduled appointment(s) -- and arrangements for payment have not been agreed upon, Peace of Mind Counseling Centers has the option of using legal means to secure the payment. This may involve hiring a collection agency or filing a lawsuit. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature and dates of services provided, and the amount due.

Person responsible for payment:

Name: _____ Relationship: _____

_____

Client or Parent/Guardian Signature Date

_____

Staff Signature Date

Peace of Mind Counseling Centers

Today's Date: _____

CLIENT CONSENT FORM

Client Name: _____

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below. Initial each section showing you have read and understood.

_____ **CLIENT/THERAPIST RELATIONSHIP**: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

_____ The therapist(s) orientation is from a Cognitive Behavioral Perspective intertwined with a Client-Centered perspective emphasizing a Christian Perspective. We approach each client with the same respect and warmth regardless of race, religion, non-religious beliefs, sexual orientation, political beliefs, national origin, color, height, weight, marital status, sex, gender identity, expression, or identity. We respect your decision to respectfully decline a Christian perspective in your treatment plan.

_____ **Yes, I am okay with my therapist(s) operating from a Christian perspective.**

_____ **No, I respectfully decline my therapist(s) use of a Christian perspective and would like religion to be exempt from my treatment plan(s) or discussion.**

_____ **IN CASE OF EMERGENCY**: If my Therapist believes that I (or my child, if the client is a minor) am in any physical or emotional danger to myself or another human being, I hereby specifically give my consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the Emergency Contact listed in my information as well as any medical or law enforcement personnel deemed appropriate.

_____ **CONFIDENTIALITY**: Peace of Mind Counseling Centers follows all ethical standards prescribed by the state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

_____ **DUTY TO WARN:** Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. If the client is a minor, the information discussed in sessions will continue to be held confidential, unless a safety issue is involved. If records are requested for a minor, it is standard procedure for a treatment summary to be provided, in order to protect the confidentiality of the minor. *Possible exceptions to confidentiality include but are not limited to the following situations: child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation, HIV/AIDS infections and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is an issue, situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose, fee disputes between the Therapist and the client, a negligence suit brought by the client against the Therapist, or the filing of a complaint with the licensing or certifying board.* If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist for any departure from your right or confidentiality that may result.

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_____ **ETHICAL AND LEGAL CONSIDERATIONS:** I understand that when I enter Peace of Mind Counseling Center's Facility, I am expected to respect the confidentiality of other clients/personnel that may be in the building. It is our goal at Peace of Mind Counseling Centers to protect the confidentiality of all who enter our facility. It is our hope that all who enter here feel safe and their confidentiality is not at risk. By signing this form, I understand that I am not to take photographs, video recordings, voice messages of any client or therapist without their written consent to do so, as well as a staff member's written consent. I also understand I am responsible to not communicate with anyone about any person I may have seen while at the facility, thus respecting their confidentiality, as well as my own. By signing this form, I also agree to indemnify and hold Peace of Mind Counseling Centers harmless for any loss or damages, including costs and attorney's fees, incurred by Peace of Mind Counseling Centers as a result of my breach of another's confidentiality.

_____ **INCAPACITY OR DEATH:** I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

_____ **RISKS AND BENEFITS:** Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

_____ **COURT MANDATED CLIENTS:** If you are mandated to counseling by the courts, it is your responsibility to schedule and attend therapy. The fee schedule and your responsibility for following appointments is the same for non-mandated clients. After 3 no shows, you will be terminated from therapy and a non-compliance letter will be sent to the judge. Progress towards therapeutic goals outlined in the agreement with the courts will be followed in therapy sessions. Non-compliance with the therapist will also result in a non-compliance letter being sent to the court or referring council. Please note the only types of recommendations the therapist will give to the referring council are compliance or non-compliance recommendations including attitudes, goal-attainment, and motivation.

Is client court mandated?

____No, client is not court mandated.

____ Yes, client is court mandated. Reasoning: _____ Judge: _____

_____ **IF COUNSELOR IS SUBPEONAED TO COURT ON YOUR BEHALF:** Due to the uncertain schedule of the courts and scheduling conflicts that will inevitably occur for the counselor and his/her other clients if he/she is subpoenaed, I understand that the counselor is to be paid for his/her presence in court. *Payment fee for requests for records or other written documents are listed below in the fee schedule section*. By initialing and signing this form, I acknowledge that I will be responsible for the following payment fees:

*Court appearances (Paid in full 1 week before court date) $250.00/hour

(Required 4- hour minimum retainer due the week of court)

No refund will be given if less than *72 hours'* notice of cancelling court.

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_____ **CONSENT TO TREATMENT:** By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment, and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child or impacting your rights with respect to consent to the child's mental health care and treatment, Peace of Mind Counseling Centers will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____ **TELEHEALTH/TECHNOLOGY-ASSISTED COUNSELING:** Possible misunderstandings should be considered in using technology-assisted counseling. Please do not use email as your method of communication during a state of emergency or crisis because we cannot guarantee a timely response. Our phone number is 501-581-7703. Please call 911 if you are in a LIFE-THREATENING EMBERGENCY BEFORE notifying our office. Clients must seek permission of the counselor before using any recording devices during the session.

_____ **CREDIT CARD ON FILE AGREEMENT:**
Unless you are a MEDICAID client, Peace of Mind Counseling Centers requires a credit card be put on file for each of our clients. Please initial next to the following statements indicating your understanding and consent. Peace of Mind Counseling Centers, PLLC agrees to charge only for reasons agreed upon in Psychotherapy, Supervision, Neurofeedback, or Consultation agreement.

_____ I understand that my card will be used for billing purposes only, including Services Rendered, Charges for Missed Appointments, and Balances of Charges not paid withing 30 days (unless otherwise arranged with billing department). Once data is entered into our billing system, this physical document will be shredded using a HIPAA secure system to protect our clients. If you choose to not sign this form, cash or check will be accepted **prior to services**.

_____ I am using Medicaid.

_____VISA _____MASTERCARD _____DISCOVER _____AMEX

Card Holder's Name: _____

Credit Card #: _____ Exp: _____ **CVV:** _____ **Zip:** _____

I understand that by signing this form, I consent to the confidentiality agreement and to the terms outlined in this document. By signing this form, I understand my role as a client and the practitioner's role as a therapist and will respect our agreement. If I have any questions, I understand that it is my responsibility to ask them.

_____

Client or Parent/Guardian Signature Date

_____

Staff Signature Date

_____

Therapist Date