PRUETT COUNSELING AND CONSULTING
INFORMATION FORM AND PAYMENT AGREEMENT (Adult)

Personal Information

Name *first* *middle* *last* *nickname*			**Today's Date:**
DOB ____/_____/_____ **Age:** _____	**Gender:** ☐ Male ☐ Female	**Street Address**	
Home Phone Number ( ) _____--_____ **OK to leave message?** ☐ Yes ☐ No		**City, State, Zip**	
Cell Phone Number ( ) _____--_____ **OK to leave message?** ☐ Yes ☐ No		**Email address: _____** **OK to communicate by email?** ☐ Yes ☐ No	

Employment

Employer **Occupation**	**Work Phone Number ( ) _____--_____** **OK to leave message?** ☐ Yes ☐ No

Family

Marital Status: ☐ Single ☐ Cohabiting ☐ Married ☐ Divorced ☐ Widowed ☐ **Other _____**	
Spouse/Partner Name	**Children (Names and Ages)**
Emergency Contact Name and Relationship	**Emergency Contact Number** **( ) _____--_____**
How did you hear about Pruett Counseling and Consulting?	

Medical Information

Current Medications (Prescribed and Over-the-Counter)

Medication	**Dosage/Frequency**	**Purpose**	**Prescribed by**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Care Physician Name and Number	**Date of Last Physician Visit (month, year)**

Name _____

PAYMENT INFORMATION

Are you responsible for payments (*co-pays, deductibles, etc.?)* ☐ Yes ☐ No **If Yes, please move to next section**	
If No, Who is responsible for payment? **Name** *first* *middle* *last*	**Client Relationship to Responsible Party:** ☐ Self ☐ Spouse ☐ Child ☐ **Other** _____
Responsible Party Contact Numbers *Home* **( )** _____--_____ *Cell* **( )** _____--_____	**Responsible Party Address** *Street Address* *City, State, Zip*

INSURANCE INFORMATION

Primary Insurance Provider:	**Name of Insured:**
Group Number:	**Contract Number:**
Insured's DOB:	**Insured's Employer:**
Insured's Social Security Number: _____--_____--_____	**Client's relationship to Insured:** ☐ self ☐ spouse ☐ child ☐ other _____

PAYMENT INFORMATION

I understand that each session at Pruett Counseling and Consulting is $100 per hour, rounded to the next half hour. All client portions of fee are due at the time of the session.

If I choose for PCC to bill my insurance company, I understand any portion of the fee not reimbursed my insurance company will be my responsibility. If another party is financially responsible for services rendered, I understand PCC will contact that person as needed to discuss financial matters.

INSURANCE INFORMATION

We will file insurance claims for you. Signing this contract gives your permission for us to collect your benefits from your insurance company. ***** It is your responsibility to verify with your insurance provider(s) that services will be covered.**

PROFESSIONAL FEES

PCC does not charge for an initial consultation. During the consultation, the patient and counselor will agree on the frequency of future visits and on their length, which usually will be approximately 50 to 60 minutes. Longer visits may be scheduled at times and will be charged at the hourly rate. Other fees for services such as telephone consultations with you or on your behalf, letters and reports on your behalf, consulting with other professionals

with your permission, preparation of records or treatment summaries, as well as time spent performing any other service you may request of your counselor may be billed at a fee proportionate to your counselor's rate. The fee for a returned check is $25.00. If you become involved in legal proceedings that require your counselor's participation, you will be expected to pay for all of the counselor's professional time, including preparation and transportation costs, even if your counselor is called to testify by another party. Because of the difficulty of legal involvement, your counselor's hourly rate for preparation and attendance at any legal proceeding is 1.5 times the normal hourly rate for other services (you can clarify specific fees with your counselor).

CANCELLATIONS AND MISSED APPOINTMENTS

In agreeing to see you, we are reserving a block of time and setting that block aside solely for your use. This time slot therefore becomes time we cannot make available for any other purpose without sufficient notice. ****** If you give at least 24 hours' notice of your intention not to use the allotted appointment time, you will incur NO charge. If you fail to provide at least a 24-hour notice, regardless of the reason for the absence, then you WILL be charged for the scheduled time at the usual rate.***

******Please Note: insurance companies do not pay for cancellations or missed appointments and often require that missed appointments be so noted on your statement.**

If at any time, you fall behind in payments due to PCC, your counselor will suspend services until such time as payments can be brought up to date. Non-payment includes a check being returned for insufficient funds.

AUTHORIZATION TO PAY INSURANCE BENEFITS

If Pruett Counseling and Consulting (PCC) is to file my insurance claims or communicate with my insurance company or its designee if required for reimbursement, I hereby authorize the release of any psychological information needed to process my claims, including sending information by fax if necessary. If I have not paid my visits in full, then I hereby now and forever authorize and direct all payments to be made directly to PCC the benefits payable to me.

CONTACTING YOUR COUNSELOR AND EMERGENCY PROCEDURES

If you need to talk to your counselor, you may leave a message, and your call usually will be returned by the next business day with the exception of vacations and holidays. If your counselor will be unavailable for an extended time, your counselor will give you the name of a colleague to contact, if necessary. Your provider may use a cell phone, which is less secure than using a land line. If you deem your situation to be critical or an emergency, go to the emergency room of the hospital of your choice and inform your counselor as soon as possible.

By signing below, I affirm that all of the information I have provided in this document is accurate and complete. I further affirm that I have read and understand all of the information in this document and agree to abide by its terms. I affirm that all information provided is accurate and complete. I agree to be responsible for all charges to my account as outlined above. I also affirm that I have been provided with written information regarding confidentiality, consumer rights, the risks and benefits of counseling, as well as emergency procedures, including the "Notice of Pruett Counseling and Consulting Policies and Practices to Protect the Privacy of Your Health Information," and "Pruett Counseling and Consulting Counselor-Client Services Agreement."

A copy of this form is as valid as the original.

_____ Date_____/_____/_____

Signature of Client

_____ Date_____/_____/_____

Signature of Responsible Party (if different from Client)

_____ Date_____/_____/_____

PCC Witness

Pruett Counseling and Consulting

COUNSELOR-CLIENT SERVICES AGREEMENT

Welcome to PCC. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is provided along with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information prior to your initial session with a counselor. Although these documents are long and sometimes complex, it is very important that you read them carefully before you start your session. You and your counselor can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between you and your counselor (and therefore between you and Pruett Counseling and Consulting). You may revoke this Agreement in writing at any time. That revocation will be binding on your counselor and Pruett Counseling and Consulting (PCC), unless your counselor has taken action in reliance on it, if there are obligations imposed on PCC by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations.

**** Please initial beside each section to indicate your agreement with the content therein.****

_____ (initial) ABOUT COUNSELING

Counseling is not like a typical medical doctor visit. It calls for an active effort on your part, involving a working partnership between you and your counselor. We will attempt to help you achieve your goals, but we cannot guarantee the outcome. Counseling has risks and benefits. Change often is accompanied by uncomfortable feelings such as depression, anxiety, guilt, self-doubt, and confusion. Change also may have a troublesome impact on some relationships. Benefits of therapy may include progress toward better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Your first few sessions with your counselor will involve an evaluation of your needs. By the end of the evaluation, your counselor will be able to offer you first impressions of what your work together 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 your counselor. Counseling involves a large commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about your counselor's procedures, you and your counselor should discuss them as they arise. If your doubts persist, your counselor will be happy to help you set up a meeting with another mental health professional for a second opinion.

_____ (initial) LENGTH OF MEETINGS AND TERMINATION OF TREATMENT

If counseling is begun, the counselor will usually schedule one 50- to 60-minute session per week at a mutually agreed upon time, although some sessions may be longer or vary in frequency. The time required for counseling varies and depends on numerous factors, such as the severity and number of problems addressed, the methods of treatment selected, and other individual factors. Because the therapeutic relationship occupies a position of importance to us as well as to you, we hope the decision to end therapy will be discussed with us in advance. Many individuals find this to be a growth-enhancing experience.

____ *(initial)* ***MINORS & PARENTS***

Clients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless the child's counselor decides that such access is likely to injure the child or the mental health professional and parents agree otherwise. Because privacy in counseling is often crucial to successful progress, particularly with teenagers, it is sometimes the counselor's policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, the counselor will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. The counselor also will provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless the counselor perceives that the child is in danger or is a danger to someone else, in which case the counselor will notify the parents of a concern. Before giving parents information, the counselor will discuss the matter with the child, if possible, and do his or her best to handle any objections the child may have.

____ *(initial)* *LIMITS ON CONFIDENTIALITY*

The law protects the privacy of all communications between a client and a counselor. In most situations, we can release information about your treatment to others only if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, prior consent. Your signature on this Agreement provides consent for those activities, as stipulated in the APWC privacy notice provided to you with this agreement.

Please read "Notice of Pruett Counseling and Consulting's Policies and Practices to Protect the Privacy of Your Health Information" for circumstances requiring disclosure of information without your consent. If one of these situations arises, we will make every effort to discuss it fully with you before taking any action, and we will try to limit our disclosures to what is necessary.

While summaries of exceptions to confidentiality documented in the accompanying privacy Notice should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

_____ **(initial)** *PROFESSIONAL RECORDS*

You should be aware that, pursuant to HIPAA, your counselor may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem may have an impact on your life, your diagnosis, goals set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that your counselor receives from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. If you provide your counselor with an appropriate written request, you have the right to examine and/or receive a copy of your records, except in unusual circumstances that may involve danger to you or others. In those situations, you have a right to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you review them in your counselor's presence or have them forwarded to another mental health professional so you can discuss the contents. In most situations, we charge a copying fee of $1.00 per page for the first 25 pages and $.25 per page for each page thereafter; also, a search fee of $5.00 will be charged. The exceptions to this policy are contained in the form provided to you entitled, *Notice of Pruett Counseling and Consulting's Policies and Practices to Protect the Privacy of Your Health Information* (Notice form). If your counselor refuses your request for access to your records, you have a right of review, which your counselor will discuss with you upon request.

In addition, your counselor may also keep a set of Counseling Notes. These notes are for your counselor's use and are designed to assist the counselor in providing you with the best treatment. While the contents of Counseling Notes vary from client to client, they can include the contents of conversations with your counselor, your counselor's analysis of those conversations, and how those conversations may affect your therapy. They also may contain particularly sensitive information that you may reveal to your counselor that is not required to be included in your Clinical Record. These Counseling Notes may be kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Counseling Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you for your refusal. You may examine and/or receive a copy of your Counseling Notes unless your counselor determines such disclosure would be reasonably likely to endanger your health.

_____ (initial) CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that your counselor amend your record, requesting restrictions on what information from your Clinical Record is disclosed to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about our policies and procedures recorded in your records, and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your counselor will be happy to discuss any of these rights with you.

____ *(initial)* BILLING AND PAYMENTS

You will be expected to pay for professional services at the time of service, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If you have insurance coverage, initial visits must be paid in full to allow time to verify your benefits and satisfy any deductible requirements. Any insurance reimbursement will be applied to your account and may be used to cover other copayments. Payment schedules for other professional services will be agreed upon when they are requested.

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

_____ **(initial)** 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. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. In an ongoing effort to balance the needs of our patients with the need to control the cost associated with the complexities of handling insurance claims, we will file insurance claims for you, and you will not be charged a filing fee for this service. Due to the high cost of billing, we will be collecting fees owed by the client at the time of check in. After 60 days, if your insurance has not paid, you will be responsible for the balance of the fees associated with that unpaid visit. We hope that you will find these policies beneficial, as we believe that they will help keep costs down for both you and us. If you have any questions regarding any of our policies, please ask your counselor.

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We might be required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your insurance carrier or other third-party payor to whom you have requested us to send invoices for reimbursement for our services.

It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract.