Comprehensive Counseling and Therapy

704 E Grand Hwy Clermont, Florida 34711
(352) 346-0753

New Client Information

Last Name of Client _____First Name_____Middle Initial____

Social Security Number of Client _____ Gender: ___M ___F

Birthdate of Client _____E-Mail Address _____

___M- Married ___S- Single ___Se- Separated ___D- Divorced ___W- Widowed __O-Other

Client Address _____

City_____ State_____ Zip Code_____

Cell Phone_____ Acceptable to leave message? __Yes __No

Work Phone_____ Acceptable to leave message? __Yes __No

Home Phone_____ Acceptable to leave message? __Yes __No

Employer or School Name & Address_____

Who Referred You? _____

Name of Emergency Contact_____

Phone_____ Acceptable to leave message? __Yes __No

Policy Holder/Responsible Party Insurance Information

Policy holder's Last name_____First name_____Middle Initial ____

*Policy holder's relationship to client: __ Self __ Spouse __ Parent/Guardian __ Other

Birthdate_____ Social Security Number_____

Address (if different from client)_____

Phone Number_____ E-Mail Address_____

Employer and Address _____

*If the client is the policy holder/responsible party please continue to Insurance Information section below.

Insurance Co. Name_____ Insured ID_____

Authorization #_____ Group ID_____

Group Name_____ Phone Number_____

1. I hereby authorize the therapist whose name appears on my insurance claim form to release any requested information (except psychotherapy notes) to my insurance company that is necessary for billing or to process my claim for payment of services.
2. I hereby authorize my insurance company to send payment directly to the therapist whose name appears on my insurance claim for all services provided.
3. I understand that it is my responsibility to be familiar with my insurance benefit and that I am financially responsible for any charges not covered by my insurance.

Print name *Signature Date

*The signature of the custodial parent or guardian is required for clients under 18 years of age.

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Informed Consent & Office Policy Statement

I. **Welcome!**

Thank you for choosing Comprehensive Counseling and Therapy. The following information will acquaint you with information relevant to treatment, confidentiality and policies. Please inform the therapist of any questions you have regarding any of these policies.

II. **Aims and Goals:**

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

III. Appointments:

Appointments are usually scheduled for 50-55 minutes. Patients are generally seen weekly decided by you and your therapist. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency the therapist may be reached at (352) 346-0753. If you are unable to contact your therapist please call your psychiatrist/physician; 911; or the crisis hotline (800) 784-2433 or (800) 273-8255.

IV. Confidentiality:

Counseling issues discussed between the therapist and identified client are important and are generally legally protected as both confidential and "privileged." Communications between the therapist and identified client will not be revealed unless required by law such as in situations as (1.) Suspected abuse or neglect of a child, elderly person or a disabled person (2.) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself (3.) Subpoena for court ordered release of information. Additionally confidentiality limits could be affected by: (a.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc…; (b.) In natural disasters whereby protected records may become exposed; or (c.) When someone other than the therapist is present during the counseling session. In the unlikely event that your therapist is unable to provide ongoing services an alternate counselor will be recommended to offer continuation of services or will refer you to the appropriate resources. In addition your mental health records will be maintained for a period of not less than 7 years.

V. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section. Medical records are locked and kept on site.

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VI. Fees:

Fee for the initial visit is $175.00
Each 50-55 minute session thereafter is $150.00

VII. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist can supply a super-bill or file the insurance claim but the client is responsible for deductibles, co-insurance, and/or co-payments. Any outstanding balances will be charged to the credit card on file. Any unpaid balances will be turned over to a collection agency after three attempts by mail to collect said funds. Cash, Check, Visa, MasterCard, American Express, and Discover are accepted.

VIII. Cancellations and Missed Appointments:

If you must cancel your appointment please notify Comprehensive Counseling and Therapy by phone (352) 346-0753 or email: comprehensivecounselor@gmail.com (messages may be left via voicemail) at least 24 hours in advance of your scheduled appointment. A charge will be incurred ($35) when cancellations are received less than 24 hours in advance or the client does not show for the session. The client is responsible for this charge since insurance companies do not reimburse for missed appointments.

IX. Returned Check Fee:

There will be a $30.00 fee for any checks returned from your bank.

X. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also contact your insurance carrier.

XI. Termination of Services:

If at any point you choose not to continue therapy please notify the therapist of the decision immediately so the chart can be closed. If you fail to reschedule an appointment within eight weeks of your last session, therapy will officially be ended and your case will be deemed closed.

XII. Consent for Treatment:

By signing below you: state that you have read and understood the Informed Consent Statement and Confidentiality Policy; have had your questions answered to your satisfaction; accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment; and understand that you may withdraw from treatment at any time. NOTE: If you are divorced from your child's other parent; please provide a copy of the Divorce decree and/or a copy of the Custody Agreement so that assurance of all appropriate consents are available at the initiation of the counseling relationship.

_____

Print name *Signature Date

*The signature of the custodial parent or legal guardian is required for clients under 18 years of age.

_____

Therapist/Witness signature Date

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Statement of Patient Rights	Statement of Patient Responsibilities
Patients have the right to: ● Be treated with dignity and respect. ● Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment. ● Their treatment and other member information be kept private. Only where permitted by law, may records be released without member permission. ● Easily access timely care in a timely fashion. ● Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan. ● Share in developing their plan of care. ● Information in a language they can understand. ● A clear explanation of their condition and treatment options. ● Information about their insurance company, its practitioners, services and role in the treatment process. ● Information about clinical guidelines used in providing and managing their care. ● Ask their provider about their work history and training. ● Give input on the patient's rights and responsibilities policy. ● Know about advocacy and community groups and prevention services. ● Freely file a complaint or appeal and to learn how to do so. ● Know of their rights and responsibilities in the treatment process. ● Receive services that will not jeopardize their employment. ● Request certain preferences in a provider. ● Have provider decisions about their care made without regard to financial incentives.	**Patients have the responsibility to:** ● Treat those giving them care with dignity and respect. ● Give providers information they need. This is so providers can deliver the best possible care. ● Ask questions about their care. This is to help them understand their care. ● Follow the treatment plan. The plan of care is to be agreed upon by the member and provider. ● Follow the agreed upon medication plan. ● Tell their provider and primary care physician about medication changes, including medications given to them by others. ● Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits. ● Let their provider know if the treatment plan is not working for them. ● Let their provider know about problems with paying fees. ● Report abuse and fraud. ● Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, I have read the HIPPA guidelines presented to me at sign-in, and that I understand this information.

_____

Client Signature Date

The signature below shows that I have explained this statement to the patient, and have offered them a copy of this form and the HIPPA form.

_____

Provider Signature Date

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Credit Card on File Agreement

Comprehensive Counseling and Therapy has implemented a new credit card policy. We kindly request our patients and/or patients' guardian/guarantor for a credit card which may be used to pay any balance that may be due on your bill. This includes No Show/Late Cancellation fee. Co-pays are still due at the time of service.

●●

By signing below, I authorize Comprehensive Counseling and Therapy to keep my signature and my credit card information securely on file in my account. I authorize Comprehensive Counseling and Therapy to charge my credit card for any outstanding balances when due.

Visa □ MasterCard □ Discover □ American Express □

Name on Card (Print): ____

Cardholder Relationship to Patient: ____

Credit Card Number: ____ Exp. Date: ___/____

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): ____ DOB: ___/___/_____

Patient Full Name (Print): ____ DOB: ___/___/_____

Patient Full Name (Print): ____ DOB: ___/___/_____

____

Cardholder's Signature Date

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

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I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization
I agree to release any applicable mental health/substance abuse information to my PCP

Name of PCP _____

Address_____

Telephone #:_____ Fax #:_____

- ☐ I agree to release only medication or other related mental health information to my PCP
- ☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.
- ☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____
Patient Signature Date

Patient Rights:
 You can end this authorization (permission to use or disclose information) any time by contacting Comprehensive Counseling and Therapy.
 If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
 You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
 You have a right to a copy of this signed authorization. Please keep a copy for your records.
 You do not have to agree to this request to use of disclose information

Information to be completed by Behavioral Health Provider

I saw_____on _____ for_____.
(Patient Name) (Date) (Reason/Diagnosis)

Summary:_____
_____
_____
_____

Carole Bezmen-Goldstein, LCSW

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Fee Schedule

Service	**Length of Appointment**	**Fee**
Initial Assessment	50-55 minutes	$175
Individual/Marital/Family Therapy	50-55 minutes	$150
Group Counseling (i.e. Socialization/Social Skills, Grief, etc…)	60-75 minutes	$60/per client
Telephone Consultation	25-30 minutes 50-55 minutes	$75 $150
Form Completion- (i.e. SSI, Disability, FMLA, letters to attorney, etc…)		$75-$100
Court On-Call Appearance	6 hour minimum required	$250/hour –50% deposit due 1 week prior to court date –NO REFUND for changes in date/time/etc…
No Show/Late Cancellation	Less than 24 hour notice by phone or email	$35

**Co-pay; deductible portion; or self-pay session fee is required at the time of your service.*

I HAVE READ, UNDERSTAND, AND AGREE TO THE FEES AND POLICIES OF COMPREHENSIVE COUNSELING AND THERAPY.

_____

Signature of client/responsible party Date