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## **Adult Personal Data & Consent to Treatment**

At Great Oaks Counseling Center it is important in starting a professional counseling relationship for you to understand both its nature and its limitations. Please review this document and feel free to ask any questions. It contains important information about our professional services, business policies, and the current legal and ethical requirements of the providers at Great Oaks Counseling Center.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
SSN: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Which would you prefer to be contacted by? \_\_\_\_\_ May we leave a message? \_\_\_\_\_

Have you been in therapy in the past? \_\_\_\_\_ If yes, when? \_\_\_\_\_  
Length of treatment? \_\_\_\_\_ Outcome? \_\_\_\_\_  
Current medications: \_\_\_\_\_  
Have you ever been hospitalized for psychological reasons? \_\_\_\_\_  
If yes, when? \_\_\_\_\_ Length of stay? \_\_\_\_\_

### **Insurance Information:**

Primary Insurance: \_\_\_\_\_ I.D.#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Policy Holder DOB: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_\_  
Policy Holder Phone #: \_\_\_\_\_ Policy Holder Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder Employer: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_

Please initial next to each paragraph:

\_\_\_\_\_ **HIPAA CONSENT FORM:** *I have read Great Oaks Counseling Center, Inc.'s "Notice of Privacy Practices" (also known as "HIPAA Consent") form either on the GOCC website or the posted copy in the office and understand that it describes how psychological and medical information about me may be used or disclosed and how I can gain access to this information. In addition, I understand that I am welcome to a copy of this HIPAA Consent form if I request it from my GOCC therapist.*

\_\_\_\_\_ **Confidentiality:** Individuals seeking mental health services should be clearly informed about their confidentiality rights. Generally, information that you discuss with your therapist in session and the written records pertaining to those sessions is strictly confidential and will not be discussed with anyone without your expressed written consent. This means that anything that is told in a therapy session will not be reported to anyone, even other family members. However, there are some exceptions to confidentiality when disclosure is required by law:

1. If a court of law orders your records in regards to a legal proceeding.
2. If you threaten to harm yourself or anyone else or you are suspected of being a risk to yourself or others.
3. If you report any abuse or neglect of a child, disabled person, or elderly person.
4. If you are using a mental health insurance policy, to pay for your visits, we may be required to provide certain diagnostic and basic treatment information in order to process your claims to obtain payment for our services.

\_\_\_\_\_ **Professional Records:** Both law and ethical standards of the profession require that appropriate treatment records be kept. As a client, you have the right to review or receive a summary of your records at any time if a request is made in writing, except in limited legal or emergency circumstances or when releasing such information might be harmful in any way. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommend records be reviewed with your therapist in session.

\_\_\_\_\_ **Fee Arrangements:** Fees for psychological services are as follows. All psychotherapy appointments are 45-50 minutes. All fees are due and payable at the time of service. Payment is accepted by credit card, personal check or cash. Psychological assessment reports are typically available within two weeks after the initial evaluation and psychological test are completed. Psychological assessment reports will not be released until full payment is rendered. If an account has an outstanding balance, a payment plan may be arranged. However, the balance must be paid within two sessions to prevent routine appointments from being ceased until the balance has been paid.

Initial Evaluation	\$175.00
Individual Psychotherapy	\$140.00
Marital/Couples Psychotherapy	\$155.00
Family Psychotherapy Initial Evaluation	\$185.00
Family Psychotherapy	\$140.00
Parent Consultation/Coaching	\$140.00
Parent Advocacy at ARD Meeting	\$150.00/hour
Psychological Testing	\$150.00/unit
Late Cancellation (less than 24 hours)	\$50.00
No Showed Appointment	\$100.00
Returned Check Fee	\$25.00

If I am not an in-network provider with your insurance company, your company may still reimburse you for a percentage of my fee. I will provide you with a coded receipt to submit to your insurance company as a reimbursement form, although your coverage may have limitations for out-of-network providers.

\_\_\_\_\_ **Canceled/Missed Appointments:** There is no charge for cancelling an appointment if notice is given more than 24 hours in advance. A fee of \$50.00 will be charged if less than 24 hours notification is given. If you fail to attend a scheduled appointment without any notification, a \$100.00 fee will be charged. These fees are not covered by any insurance company and will be the responsibility of the client to pay before the next appointment. If an appointment is missed, follow up appointments will not be held without contact from the client to reschedule. As a courtesy reminder, our office will attempt to contact you by phone or email prior to your appointment. It is the responsibility of the client to keep your therapist informed of any changes in contact information.

\_\_\_\_\_ **Court Testimony:** We do not testify in court as an expert witness. If you are being seen for marital therapy, your therapist will not be available for court testimony for either partner. In rare and unusual situations where your therapist might be required to testify in civil court, we will require payment of the standard fee of \$140.00 per hour.

\_\_\_\_\_ **Emergencies:** If there is an emergency during your treatment process, either during or outside a therapy session, your therapist will do whatever can be done, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. This may include contacting the person you designate below as your emergency contact. Additionally, your consent is not required if you need emergency treatment, as long as your consent is sought after treatment is rendered, or if attempt is made to obtain your consent and you are unable to communicate. If you experience an emergency outside of your therapy sessions, you may call 911 or go to your nearest Emergency Room for a risk assessment to determine your need for hospitalization to ensure your safety.

**Emergency Contact:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Relationship to client: \_\_\_\_\_

YES     NO    I have carefully read, understand, and agree to comply with the above office policies and consent for treatment for psychological services.

YES     NO    I understand that the psychological services are voluntary and that I can discontinue at any time.

YES     NO    I consent to the electronic transmission of data (e.g., email, fax) as a means of communicating with the clinician and other individuals who are involved in my treatment.

YES     NO    I understand that, to improve the likelihood that I receive positive outcomes from therapy, my clinician might consult with other practitioners at Great Oaks Counseling Center.

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions or concerns at any point during the therapy process.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_