# Heartland Counseling Center

400 N. Washington Street, Suite 229
Farmington, MO 63640
573-218-9653

2909 Independence Street
Cape Girardeau, MO 63703
573-803-1402

16 Municipal, Suite D
Arnold, MO 63010
636-333-2641

Client Name _____ Male/ Female
(Last) (First) (M. I.)

Date of Birth_____ Social Security # _____

Address_____

City_____ State_____ Zip Code_____

Phone Number _____ Cell Phone #_____

Email:_____

Medical Diagnosis _____

Medications _____

Employer _____Employer's Phone # _____

Spouse/Significant Other _____

Spouse/Significant Other Phone Number _____

Spouse or Significant Other's Employer _____

Spouse or Significant Other's Employer's Phone # _____

Emergency Contact _____Phone # _____

Insured's Name and Date of Birth_____

Address (if different from patient) _____

Insurance_____ Insurance ID Number _____

From time to time, our office sends correspondence to patients or families about developments in the practice, upcoming programs and information about counseling-related topics that we believe may be of value to you. At any time, you can ask to be excluded from this mailing list by informing Stephanie Anderson, Administrative Director, in person, by telephone, or email. For routine communication, Heartland Counseling Center will generally contact you by calling your primary phone number and leaving a voicemail, if necessary. This includes, but is not limited to weekly appointment reminder calls.

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## Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself by

(name of therapist) _____.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
- The risks, benefits, side effects and alternatives of treatment as well as the consequences of noncompliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
- I understand that I may terminate treatment at any time.
- I understand that what is discussed in therapy is confidential unless and until I (the client) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
  1. The therapist believes that I am in danger of hurting myself or someone else, and
  2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed Name Relationship to Patient (if applicable)

_____ _____
Witness Signature Date

PRIVACY NOTICE

I have received the Heartland Counseling Center Notice of Privacy Practices. My signature acknowledges I have received the Notice.

SIGNATURE: _____

DATE: _____

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## Financial Information

REGULAR THERAPY SERVICES: Our therapy sessions are $135.00 per hour. An hour of therapy is considered 45-50 minutes, with the remaining time used for the therapist to complete related paperwork, collateral phone calls, etc., that may be necessary for the benefit of treatment. We honor negotiated rates with multiple insurance companies. We also offer a Sliding Fee Scale for clients without insurance benefits. Payment or fee arrangements must be worked out before the end of the first meeting with the therapist.

INSURANCE INFORMATION / THIRD PARTY PAYMENT: We are licensed mental health providers so many insurance plans will help pay for therapy. We are considered Specialists by most insurance companies. You may obtain benefit information from the customer service number on your insurance card or from your agent. **Your insurance co-pay must be made at each visit**. There is a possibility that your health insurance plan will not cover outpatient mental health services. In either case, **the financial responsibility for services is yours as a client/parent**. Please note: Occasionally contact with collateral professionals may be needed and most insurance companies do not cover these expenses. This will require us to bill you directly.

RETURNED CHECKS:
A $25.00 fee will apply for all returned checks, in addition to the amount originally owed. In the event of a returned check, your privilege to pay by check during future visits may be terminated

PATIENT/PARENT/GUARDIAN AGREEMENT:
Heartland Counseling Center has notified me that there is the possibility that outpatient mental health services may not be a covered benefit by my health insurance. **If my insurance is not in effect today or a service is not a covered benefit, I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur.** I give this office permission to release any information to my insurance company during treatment of me or my family, which is necessary to obtain authorizations or support any insurance claims on this account and secure timely payments due to the assignee or myself.

ASSIGNMENT OF BENEFITS:
I hereby assign medical benefits, including those from government-sponsored and other health plans to Heartland Counseling Center. A photocopy of this assignment is to be considered as good as the original. I agree to the above statements and attach my signature below.

_____ _____
Client's (or parent/guardian's signature) Date

_____
Printed name

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## Credit Card Payment Policy

In an attempt to keep our clients' accounts up to date, we have implemented a very successful system of payment. By having your credit card information on file, we can efficiently update your account after each session. Since deductibles and co-insurance are not collected until after claims have been processed, having your credit card information on file will ensure timely and convenient payment. Heartland Counseling Center will mail a bill to you after your insurance company has processed the claim(s). At this time, you may choose to either remit payment by another means or we will automatically charge the amount due to your credit card after 15 days of mailing the bill.

In addition, our cancellation policy at Heartland Counseling Center requires that 24-hour notice be given if it is necessary to cancel or change an appointment. The following charges will be applied:

1st Late cancellation or failure to show for an appointment- Written warning
2nd Late cancellation or failure to show for an appointment- $30 Charge
Additional late cancellations or failure to show for appointments- $60 Charge each time

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I have read this policy and understand that my credit card may be charged for the above mentioned fees. I also understand that my insurance will not cover cancellation charges.

I authorize Heartland Counseling Center to charge this account for co-pays, self-pays, deductible charges, co-insurance, and/or cancellation fees as explained above.

**Credit Card Information--**

Card Number_____

Visa/Master Card/Discover Expiration Date:(Mo./Yr.)_____ ZIP Code:_____

Name of Card holder:_____

Address of Card holder: _____

_____ _____
Signature of Cardholder Date

*If you have any question about this policy, please discuss it with the Administrative Director.*