

Solace



Counseling Associates

Date: _____

Intake Therapist: _____

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS AND SIGN BOTTOM

Client Name (Print) _____

Date Of Birth _____

APPOINTMENT CONFIRMATION CALLS/TEXTS/EMAILS

_____ I authorize Solace Counseling Associates INC, to leave phone messages, text messages, or e-mail messages, and appointment reminders. I understand that Solace Counseling Associates INC cannot guarantee the privacy or confidentiality with these communication modalities.

(please check all that apply). Phone messages _____ Text messages _____ E-Mail messages _____

In case of emergency, please provide us with a name and number of someone we have permission to contact.

Name: _____ Relationship: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES

_____ I have read, understand, and been offered a copy of the Notice of Privacy Practices (HIPAA) provided to me by Solace Counseling Associates.

_____ I understand the limits of confidentiality agreement explained to me.

NOTICE OF INFORMED CONSENT

_____ Therapist has explained Solace's Informed Consent and I was offered a copy. I understand and agree to the following.

- I have voluntarily entered into counseling/therapy with Solace Counseling Associates INC.
- I have discussed the risks and benefits of treatment with my individual therapist, and consent to continue therapy.
- I have discussed my diagnosis and treatment options, with my therapist

CONSENT TO THERAPY FOR MINOR CLIENT

_____ I voluntarily consent for treatment for my minor child to be treated by the therapists at Solace Counseling Associates INC. Additionally regarding adolescents, I read, understand, and agree to, the Special Confidentiality Notice as stated in the Adolescent Intake Form.

RELEASE OF INFORMATION FOR PAYMENT PURPOSES

_____ I will be utilizing my health insurance benefits for services. I understand and I authorize Solace Counseling Associates INC to release the following information to my insurance company as required by insurance company to submit claims: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, AND TREATMENT STRATEGY.** I understand that this is

Solace Counseling Associates

a requirement of my insurance company for me to utilize my insurance benefits, And I authorize Solace to receive payments from my insurance for services received.

FINANCIAL POLICY

_____ I have read and understand the Financial Policy; and understand I can request a copy of these documents for my records.

_____ I understand that my insurance may have a high deductible and I am responsible for the balance remaining after insurance is processed as listed.

_____ I understand, according to my insurance benefits, a co-pay of _____ due at each session.

_____ I choose to be a private pay client. I understand no PHI will not be released to an insurance company. My Therapist and I have agreed to the rate of _____ per session, payable at the end of each session.

_____ If I am struggling with payments it is my responsibility to let my therapist know and negotiate a workable payment plan. I understand that I can be involuntarily discharged from therapy for non-payments (written notice will be mailed, this can be appealed).

_____ I would like to provide Solace with the name of a person I give permission to speak with regarding billing

questions. _____

Relationship _____

TERMINATION OF THERAPY

_____ I understand that therapy can be terminated by either myself or the therapist. If I choose to end treatment, I understand that I am encouraged to discuss the decision with my individual therapist so the most appropriate discharge plan may be facilitated.

_____ I also understand that after 45 days from my last my therapy appointment my file will be deemed inactive. At which time, your therapist will no longer be liable for your mental health. Please understand, your file can be reactivated at any time by scheduling an appointment and reengaging in therapy.

_____ I understand I can be discharged from treatment non-voluntarily for the reasons listed below, and that I will be notified of a non-voluntary discharge in writing.

- I exhibit physical violence or verbal abuse, carry a weapon, or engage in illegal acts at the clinic.
- I do not make payments or a payment arrangement in a timely manner.
- After 3 missed, scheduled appointments (No shows)
- I understand that I can appeal Solace Counseling Associates' decision if I am discharged non-voluntarily.
- Not complying with therapists recommendations for clients needing a higher level of care.

NOTICE OF SUPERVISION OF MENTAL HEALTH PRACTITIONER

_____ I understand my therapist/counselor is working under the supervision of either Elizabeth Benson MA, LMFT, Deborah Peterson MA, LPCC, or Deanne Shaw MA, LMFT.

I UNDERSTAND ALL THE INFORMATION ABOVE AND IT WAS DISCUSSED WITH ME BY MY THERAPIST

DATE _____ SIGNATURE _____