Client Information and Verification Form

Welcome new client! Thank you for choosing to enter into therapy. Below you will find information regarding therapy expectations and policies. Your therapist will be happy to answer any questions you may have regarding this information.

Client/Therapist Relationship:

You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of bartering.

Risks and Benefits:

Counseling and psychotherapy are beneficial but as with any treatment there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, development of healthy coping strategies and specific problem solving. These benefits cannot be guaranteed. It is the Therapist's desire however, to work with you to attain your personal goals for counseling and/or psychotherapy.

It is your responsibility to provide 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, completing questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do in between sessions than on what happens in the session.

The Therapist's goal is to provide the most effective therapeutic experience available to you. If at any time you feel that we are not a good fit, please discuss this matter with your therapist so we can determine if transferring to a more suitable Therapist is right for you.

Appointments:

Appointments are usually scheduled on a weekly or bi-weekly basis and are for **50 minutes**. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and your Therapist. Please be mindful that your scheduled time is reserved especially for you. If you have very specific times you need to come in of if you are only able to come in during times of high demand, it is important to schedule your appointments in advance. We will try to accommodate you as best we can.

Cancellation Policy:

If you need to cancel or change your appointment, please email or call our office at 239-495-7773 at least 24 hours in advance. This will free your appointment time for another client. A credit card

number will be taken at the time of appointment scheduling and will be charged in the event of a missed appointment unless 24 hours' notice is given or other arrangements have been discussed. The fee is $75.00 for a late cancellation or missed appointment. Insurance companies do not reimburse for missed or late cancelled appointments. If two sessions in a row are cancelled with less than 24 hours' notice, your therapist may request to speak with you before continuing to reschedule appointments.

Professional Fees:

Our fees at Compass Counseling are $150.00 for 50 minute individual or couples therapy sessions
$75.00 Late Cancellation or No show fee
$ 40.00 returned check fee

We are in-network with most major insurance companies. We will bill your insurance. It is not a guaranteed form of payment and you will be responsible for the charges if your insurance does not cover our services.

If you become involved in any court or legal proceedings that require my participation, you will be expected to pay for all of the therapist's professional time, including preparation and transportation costs, even if I am called by another party. The fee is 175.00 per hour for preparation, communication, travel and attendance at any legal proceeding. A three hour minimum payment of $525.00 is due in advance for our time.

We accept cash, checks, Debit, Mastercard, Visa and Discover Cards for payment.

Emergencies:

You may encounter a personal emergency that will require prompt attention. If this happens, please contact your local Crisis Center, hospital or 911. Every attempt will be made to schedule you as soon as possible after you receive emergency services or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, attempts will be made to return calls in a timely manner. When out of town travel is planned, your Therapist will make reasonable attempts to inform you of this absence and develop a plan with you to be used during this absence. **Please use telephone communications for emergencies, not text or email.**

Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 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) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.; 4) in natural disasters whereby protected records may become exposed, or 5) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members about issues discussed.

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 above. Medical records are locked and kept on site.

In order to give you the most complete and helpful care, the Therapist may consult with other professionals in the field. Supervision sessions with other professionals may occur to ensure the Therapist is practicing ethically and competently. In this case, the Therapist may discuss details of your case however specific identifying information will not be provided and confidentiality will be maintained between the Therapist and the other professionals involved.

If you are participating in a group, couples or family counseling, reasonable attempts to ensure confidentiality will be taken but absolute confidentiality cannot be guaranteed.

Please note that if you send your Therapist a text message or email that it is not secure and your confidentiality cannot be guaranteed. **Please use telephone communications for emergencies not text or email.**

Social Media Policy:

In accordance with the ethics of the counseling profession, the Therapists or staff at Compass Counseling Associates does not accept friend or contact requests from current or former clients on Facebook or other social media sites. Doing so has the potential to compromise your confidentiality and our respective privacy. The Therapists will not write professional endorsements for clients due to the potential for violating the ethical code on dual relationships.

Compass Counseling Associates, LLC does have a company Facebook page where we post counseling related information that you are welcome to follow. Some Therapists may also have a LinkedIn account where professional information is posted.

Consent for Treatment:

By signing this client information and consent form as the client or guardian of said client, I acknowledge that I have read all three pages, understand and agree to the terms and conditions contained in this form in its entirety. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving a mental health assessment, treatment and services for me (or my child if said child is the client) and I understand that I may stop such treatment or services at any time.

By signing below, you are stating that you have read the above and understand the policy statement and that you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient (please print)_____

Signature:_____

Date:_____

Therapist/Witness:_____

Acknowledgement

Your signature below acknowledges you have read and understand the HIPPA Notice of Privacy Practices. A copy is available at your request.

Signature:_____ Date:_____

Patient Registration/ Benefit Verification Form **Therapist:_____**

Name: _____ Date: _____

D.O.B.: _____S.S.#: _____Marital Status: _____

Address: _____

City: _____State: _____Zip: _____

Home Tel #: _____ Mobile Tel #:_____ Can we text you? _____

Can we leave a message? _____ E-mail: _____ Can we email you? _____

Emergency Contact: _____Tel#: _____

Referred by: (Name) _____Tel#: _____

Please check: Self-pay _____ Insurance _____ EAP _____Other _____

Guarantor Information

Name: _____ D.O.B.:_____ Sex:_____

S.S.#: _____Relationship to Patient: _____

Employer: _____

**If Insurance, Please fill out the following as completely as possible to help the billing process:

Insurance Company: _____

Phone#: _____ Member #: _____Group #: _____

Authorization required: _____ Authorization #: _____

Number of visits: _____ Authorization begins /expires: _____

Effective Date of Insurance_____ Deductible: _____ Amt. met: _____

In network? _____ Out of network?: _____

Secondary Insurance (if applicable) _____

Claims mailing address_____

For office use only:

Reference/Confirmation number _____ *Date:*_____

*Spoke with:*_____ ***Collect from Client each visit:*_____**

Compass Counseling Associates, LLC
9180 Estero Park Commons Blvd. Suite 2
Estero, Florida 33928

Financial Policy

Thank you for choosing Compass Counseling Associates for your professional services. The following is our financial policy, which we require you read, agree to and sign prior to any treatment. This policy is strictly enforced with all patients.

Payment Terms

Full payment is due at time services are rendered. We accept as payment:

- Cash/Check
- MasterCard/Visa

Health Insurance Terms

If Applicable, Please read and initial the following:

_____ I understand that my insurance company does not guarantee payment and that I am responsible for payment of series if my insurance company fails to cover the cost of therapy.

_____ I understand that I am responsible for finding out my own insurance benefits and authorizations as necessary and cannot rely on Compass Counseling Associates to always have this information in a timely manner.

_____ I authorize Compass Counseling Associates to release pertinent information concerning my care to my insurance company.

_____ I authorize and request my insurance company to pay Compass Counseling Associates the amount due for my pending services.

_____ I authorize the release of information to any agency necessary for payment on my account.

_____ I am responsible to notify Compass Counseling Associate's office of any changes in my insurance policy/provider as soon as possible.

Court Terms

There is a $525.00 minimum fee that needs to be paid in advance if this therapist is requested to be an expert witness in court for any matter involving the client. This covers travel and preparation. Every hour thereafter is charged at a rate of $175.00.

Returned Checks

If a check is returned unpaid or non-sufficient funds, there will be a **$40.00 returned check fee**. Fees may be recovered using electronic debit through your financial institution. Checks will no longer be accepted once a check is returned unpaid or non-sufficient funds.

Collection Terms

Any account past due 60 days will be turned over to a collection agency. All applicable collection fees will be the patient's full responsibility. Fees for collection are equal to 50% of the past due amount.

Cancellation/Missed Appointments

As a courtesy, we require a 24 hour cancellation notice prior to the scheduled appointment. Individual appointments not canceled within 24 hours will be charged a fee of $75.00 which must be paid prior to next appointment.

Acknowledgement

Your signature below acknowledges you have read, understood, and agree to the terms of our **FINANCIAL POLICY.**

Signature:_____ **Date:**_____

Print Name: _____

Compass Counseling Associates, LLC
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Estero, Florida 33928