OFFICE CONSENT

Center for Child Development, INC

Delaware Center for Counseling and Wellness, Inc.

262 Chapman Road 100

Newark, De 19702

302-292-1334

Fax: 302-292-1349

Welcome! We look forward to helping you and your family to find solutions to the difficulties you face. Please read over the packet of forms carefully. If you have any questions, please be sure to speak with your therapist.

Lisa R. Savage, LCSW is the practice owner and manager. She is happy to address any concerns or questions that your therapist is unable to. Annette Hunter is the billing/office manager and can help navigate insurance issues. Please be sure to call your insurance company as soon as possible to get an understanding of what your financial responsibility is. Many plans are changing and we don't want you to be caught off guard with surprise bills. **You are responsible for any balance after your primary insurance pays. This includes co-pays, co-insurance and deductibles. This does not apply to clients with Medicaid. PAYMENT IS EXPECTED AT TIME OF SERVICE. We require all clients with a copay or deductible to keep a credit card on file. We do not allow clients to carry a balance.**

It is your responsibility to know your insurance benefits. Although we are providers with many insurance carriers, CCD may not be a provider of your plan. If your insurance plan requires a referral authorization, you will need to contact your primary care physician to request this or to confirm that an authorization has been issued properly prior to your appointment

Again, welcome to this safe space and be confident that we will guide you on the path to healing.

Cordially,

Lisa R. Savage, LCSW

2018

OFFICE CONSENT

Client's name____

DOB_________________ Gender: M/F/Transgender (circle)

Parent's name, if client is a
child____

Address: ____
____

Email address____ Would you like to be added to our email list? Yes or no (circle)

Telephone number_____________________ Cell Phone number____________________

Emergency Contact____number_______________

Employer OR School name____

Primary Care Physician____________________________________ Telephone _____________

Are you on any medications? If yes, please
list____
____

Does the client have any health problems that we should know about circle? **Y/N**. Please
describe____

Insurance Information. Please answer all questions.

Name of Insured____________________________________ Birth date of Insured______________

OFFICE CONSENT

ID#____Group#___________________________

Insurance Company____

If the client has a secondary insurance, please provide the following:

Name of Insured____

Date of Birth_________________

Name of Insurance Company____

Id#_______________________________________

By signing below, you are giving the therapist and CCD permission to bill your insurance company for services. You are also giving the therapist permission to release information necessary to bill insurance company. Your therapist will only release information that is necessary for billing purposes.

Signed____Date________________

Our current fees are as follows:

- Initial Intake Appointment (60 minutes): $160.00
- Subsequent Therapy (37- 57 minutes): $130.00
- Couples Therapy or Family Therapy (50 minutes): $140.00

If you use your insurance, most insurance agreements require you to authorize us to provide a clinical diagnosis and, sometimes, additional clinical information, such as treatment plans or summaries before they will pay benefits. If your insurance company contacts me and request additional information, we will not release any information without first discussing the insurance request with you. We will obtain your written authorization before releasing any information. Insurance companies claim to keep information confidential, but you should check with your insurance company directly if you have questions about their confidentiality practices.

It is important to remember you always have the right to pay for services privately to avoid the issues described above.

OFFICE POLICIES
You will receive a copy of this

To prevent misunderstandings about office policies, please read the following:

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law or by court order. The law requires disclosure where there is a reasonable suspicion of

child abuse, elder abuse or neglect; where a client presents a danger to self, to others, or to property; is gravely disabled; or is significantly impaired from drug and/or alcohol use. In these emergency situations, therapists will do whatever they can, within the limits of the law, to prevent clients from injuring self or others and to ensure that clients receive the proper care. Within CCD, therapists share on-call responsibilities. All CCD therapists are legally bound to keep disclosed information confidential.

In judicial proceedings, if a judge orders the records released, we must release the records. In addition, we may be ethically and legally required to act to protect others from harm even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we may be mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we may have to take protective action through notifying the potential victim, police and/or facilitating hospitalization of the client). If we believe a client is a serious threat to harming his or her self, we may have to take protective action (arranging for hospitalization, contacting family/significant others for notification and/or contacting the police.)

We will maintain client case files for 7 years from the last session date, or until the client becomes 24, whichever is later.

TELEPHONE & EMERGENCY PROCEDURES: If you need to reach your (or your child's) therapist between appointments, you may leave a message 24 hour a day, 7 days a week, on his/her voice mail at (302) 292-1334. If your call is urgent and a therapist does not call you back immediately, please call the Rockford Center Needs Assessment at (302) 996-5480, Psych Crisis of Christiana Care Health Systems at (302) 428-2118, the Crisis Intervention Services at (302) 577-2484 or (800) 652-2929, or Meadow Wood Hospital at (302) 328-3330. If your call is a life-threatening emergency, you should go immediately to the closest hospital or call 911.

PAYMENTS: At each session, payment is expected for any fees due. Missed appointments will be charged to you at the therapist's usual and customary rate of 130.00 unless you cancel 24 hours before the scheduled appointment. Monday appointments must be cancelled by the previous Friday. Telephone conversations, site visits, report writing and/or form completion, consultation with other professionals, reading records, longer sessions, and/or travel time will be charged at the therapist's standard, non-contractual rate of 130.00 per pro-rated hour. Requests to release your records will be subject to an administrative charge.
Please note that your payment is due at the time of your visit. As part of your insurance plan, you signed an agreement that you will pay your co-pay, deductible and/or co-insurance.

LITIGATION LIMITATION: Due to the nature of the therapeutic process, which often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorneys, nor anyone else acting on your behalf, will call on your (or your child's) therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If this occurs, you will be billed $1040.00 as a retainer. The fee of 1040.00 must be paid in full (cash or credit card) within 24 hours prior to the court date. You will be billed for any time that extends beyond 8 (eight) hours at the rate of 130.00 for a court appearance. It will have to be paid before your next appointment. Please note, we also charge a fee of 200.00 for records preparation. Court fees are not reimbursable by your insurance company.

TERMINATION: If at any point the therapist assesses that he/she is not effective in helping a client reach the therapeutic goals, the therapist will discuss it with you. If appropriate, treatment will end and you will be given referrals to other treatment providers. You also have the right to terminate services at any time. If you wish to do so, please inform your therapist directly so the necessary steps may be taken to discharge you from care and close your file. If you do not show up for a scheduled appointment and your therapist does not have contact with you for 6 weeks, your therapist will assume that you are terminating services, discharge you from care, and close your file.

LATE CANCELLATION AND NO-SHOW POLICY

OFFICE CONSENT

Please note that we have a strict no show or late cancellation policy. A no show is defined as not calling to cancel your appointment. A late cancellation is calling to cancel the same day as your scheduled appointment. If you no show, you will not be rescheduled until you pay our no-show fee of **130.00**
If you late cancel, you will also be assessed a penalty of **$65.00.** You will not be rescheduled until you pay this fee. Your therapist reserves the right to terminate services based on your violation of this policy.

Social Media Policy

To maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. Your therapist will not accept friend or contact requests from current or formatter clients including, Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings, or grades from clients on websites through any means. We will not respond to testimonial, ratings or grades on websites, whether positive or negative, to maintain your confidentiality. Our hope is that you bring concerns about our work together to the therapy session so we can address concerns directly.

HIPPA POLICY

Please see and read attached.
Check here to indicate you've received a copy. Also ☐ Available on our website and in the office.

I have read the Office Policies. I understand them and agree to abide by them. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

Signature____ _____________________
Date__________________

Therapist's signature____**Date**_____________

Problems and Concerns

What is the greatest concern for which you're seeking counseling?

Do you have thoughts of feelings of hurting yourself? If so, have you acted on them?

OFFICE CONSENT

Have you been in counseling previously? If so where and what were the results?

What goals would you like counseling to help to achieve?