

**Adult Client Information Form**

*\*This form is completely confidential\**

Today's date: \_\_\_\_\_

Your name: \_\_\_\_\_  
Last First Middle Initial

Date of birth: \_\_\_\_\_ Policy Holder's S S #: \_\_\_\_\_

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widow / Widower

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

Referred by: \_\_\_\_\_

- May I have your permission to thank this person for the referral?  
 Yes  No
- If referred by another clinician, would you like for us to communicate with one another?  
 Yes  No

Person(s) to notify in case of any emergency: \_\_\_\_\_  
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): \_\_\_\_\_

Please briefly describe your presenting concern(s): \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? \_\_\_\_\_

*\*The following information on this form will help guide your treatment.  
Please try to fill out as much as you are comfortable disclosing.\**

**MEDICAL HISTORY:**

Please explain any significant medical problems, symptoms, or illnesses: \_\_\_\_\_

\_\_\_\_\_

**Current Medications:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? \_\_\_\_\_

Do you consume caffeine? YES NO If YES, how much per day? \_\_\_\_\_

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? \_\_\_\_\_

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? \_\_\_\_\_

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): \_\_\_\_\_

\_\_\_\_\_

Previous psychiatric hospitalizations (Approximate dates and reasons): \_\_\_\_\_

\_\_\_\_\_

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO  
(Please list approximate dates and reasons): \_\_\_\_\_

\_\_\_\_\_

Height \_\_\_\_\_ Weight (if applicable) \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Sexual Identity: Heterosexual\_\_ Lesbian\_\_ Gay\_\_ Bisexual\_\_ Transgender\_\_ In Question\_\_

**FAMILY:**

How would you describe your relationship with your mother? \_\_\_\_\_

\_\_\_\_\_

How would you describe your relationship with your father? \_\_\_\_\_

\_\_\_\_\_

Are your parents still married? \_\_\_\_\_ If they divorced, how old were you when they separated or divorced, and how did this impact you? \_\_\_\_\_

\_\_\_\_\_

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: \_\_\_\_\_

\_\_\_\_\_

How many sisters do you have? \_\_\_\_\_ Ages? \_\_\_\_\_  
How many brothers do you have? \_\_\_\_\_ Ages? \_\_\_\_\_  
How would you describe your relationships with your siblings? \_\_\_\_\_  
\_\_\_\_\_

**RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:**

Currently in Relationship? \_\_\_\_\_ How Long? \_\_\_\_\_ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? \_\_\_\_\_ How Long? \_\_\_\_\_ Previously Married/Life Partnered? YES NO  
If so, length of previous marriages/committed partnerships \_\_\_\_\_

Do you have Children? \_\_\_\_\_ If YES, how many and what are their ages: \_\_\_\_\_

Describe any problems any of your children are having: \_\_\_\_\_  
\_\_\_\_\_

List the names and ages of those living in your household: \_\_\_\_\_  
\_\_\_\_\_

Please briefly describe any history of abuse, neglect and/or trauma: \_\_\_\_\_  
\_\_\_\_\_

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: \_\_\_\_\_  
\_\_\_\_\_

Is spirituality important in your life and if so please explain: \_\_\_\_\_  
\_\_\_\_\_

Briefly describe your diet and exercise patterns: \_\_\_\_\_  
\_\_\_\_\_

**EDUCATION & CAREER**

High School/GED \_\_\_\_\_ College Degree \_\_\_\_\_ Graduate Degree (or Higher) \_\_\_\_\_ Vocational Degree \_\_\_\_\_

What is your current employment? \_\_\_\_\_  
Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant? \_\_\_\_\_  
\_\_\_\_\_

What do you think are your strengths? \_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

**FAMILY HISTORY OF (Check all that apply):**

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				“Nervous Breakdown”			

**Any additional information you would like to include:**

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# Sheltered Cove Counseling Center

6488 Spring St. Ste. 102, Douglasville, GA 30134

770-949-1595

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## **INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT**

Welcome to *Sheltered Cove Counseling Center*. We are very pleased that you selected our facility for your therapy, and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist or group leader, policies regarding confidentiality and emergencies, and several other details regarding your treatment here at *Sheltered Cove Counseling Center*. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

### **Theoretical Views & Client Participation**

It is our belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with your therapist/group leader at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problems with our assistance. It is our intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without the therapists here at *Sheltered Cove Counseling Center*. We also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth, and we are very committed to helping you in whatever way seems to produce maximum benefit.

### **Confidentiality & Records**

Your communications with your therapist will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our business office. Additionally, your therapist will always keep everything you say to him or her completely confidential, with the following exceptions: (1) you direct your therapist to tell someone else and you sign a "Release of Information" form; (2) your therapist determines that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does provide him or

her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. The state of Georgia has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee that the appeal will be sustained, but we will do everything in our power to keep what you say confidential.

Please note that in couple's counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Please initial that you have read this page \_\_\_\_\_

## **Structure and Cost of Sessions**

Your therapist agrees to provide psychotherapy for the fee of \$120 per 50 minute intake session, \$95 per 50 minute ongoing session, unless otherwise negotiated by you or your insurance carrier. Doing psychotherapy by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to help you. Telephone calls that exceed 10 minutes in duration will be billed at \$2.00 per minute. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment, and we will provide you with a receipt of payment. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$25 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies. As a courtesy to you, we will attempt to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

## **Cancellation Policy**

In the event that you are unable to keep an appointment, you must notify your therapist at least 24 hours in advance. If our Office is closed at the time of cancellation be sure to leave detailed message with time and date of the appointment to avoid fees. If such advance notice is not received, you will be financially responsible for the session you missed by paying a \$65.00 fee. Please note that insurance companies do not reimburse for missed sessions.

## **In Case of an Emergency**

*Sheltered Cove Counseling Center* is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, your therapist will return phone calls within 24-48 hours. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Ridgeview Institute at 770.434.4567 or
- Peach Ford Hospital at 770.454.5589.
- Call 911.
- Go to your nearest emergency room.

## **Professional Relationship**

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy, your relationship with your therapist has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the

relationship of therapist and client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of our clients the best care, your therapist's judgment needs to be unselfish and purely focused on your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

You should also know that therapists are required to keep the identity of their clients secret. As much as your therapist would like to, for your confidentiality he or she will not address you in public unless you speak to him or

her first. Your therapist also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, your therapist will not be able to be a friend to you like your other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Please initial that you have read this page \_\_\_\_\_

### **Statement Regarding Ethics, Client Welfare & Safety**

***Sheltered Cove Counseling Center*** assures you that our services will be rendered in a professional manner consistent with the ethical standards of the [American Psychological Association](#) and/or the [American Counseling Association](#) and/or the [National Association of Social Workers](#). If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or her know immediately. If the two of you are unable to resolve your concern, please contact Lisa Klinger at 770-949-1595..

Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, your therapist, with your participation, will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Please initial that you have read this page \_\_\_\_\_

We are sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies of your relationship with your therapist/group leader, and you are authorizing your therapist/group leader to begin treatment with you.

\_\_\_\_\_  
**Client Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Signature**

**If Applicable:**

\_\_\_\_\_  
**Parent's or Legal Guardian's Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent's or Legal Guardian's Signature**

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

\_\_\_\_\_  
**Therapist's Signature**

\_\_\_\_\_  
**Date**

# No Show or Late Cancel Agreement

I understand that I will be charged a \$**65.00** fee if I:

Don't show up for my appointment.

Cancel or reschedule my appointment with less than a 24 hour notice.  
If our Office is closed at the time of cancelation be sure to leave detailed message with time and date of the appointment to avoid fees

## **Sheltered Cove Counseling Center**

6488 Spring Street  
Douglasville GA 30134  
(770) 949-1595

## **Credit Card Payment Authorization Form**

Sign and complete this form to authorize **Sheltered Cove Counseling Center** to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated below.

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### **Please complete the information below:**

I \_\_\_\_\_ authorize **Sheltered Cove Counseling Center** to charge my credit card.  
(full name)

account indicated below for **\$65.00**. This payment is for reasons indicated above  
(amount)

Billing Address \_\_\_\_\_

Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_

Account Type:  Visa       MasterCard       AMEX       Discover

Cardholder Name \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the reasons described above, for the amount indicated above only, I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company.



Effective 04/14/2003

## Notice of Sheltered Cove Counseling Center Inc. Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (*PHI*), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes.

“Psychotherapy Notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Composite Board of Licensed Professional Counselors, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- Worker’s Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### ***IV. Patient’s Rights and Therapist’s Duties***

##### **Patient’s Rights:**

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### **Therapist’s Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice via U.S. regular mail.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Lisa Klinger, Compliance Officer at 770-949-1595.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to the attention of your therapist's name c/o Lisa Klinger, Compliance Officer at Sheltered Cove Counseling Center, Inc. at 6488 Spring St., Suite 102, Douglasville, GA 30134.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. Regular Mail.

Print Client Name: \_\_\_\_\_

_____	_____
Signature	Date
Patient (18 Years and older) / Legal Guardian	

\_\_\_\_\_

Print Name

\_\_\_\_\_ I would like a copy.      \_\_\_\_\_ I decline a copy of this document.

## PAYMENT AGREEMENT

### RESPONSIBLE PARTY INFORMATION

All payments (deductible, co-pay, or self-pay rate) will be made *each visit* before services are rendered. I am aware that payments may be rendered via Cash, Check or Credit Card I will be charged a fee of \$25.00 for NSF checks. This fee and the past due amount is due upon request for payment.

**24-Hour Cancellation Policy:** 24-hour notice is required. If our Office is closed at the time of cancellation be sure to leave detailed message with time and date of the appointment to avoid fees. If I do not cancel 24 hours in advance, I will be charged a \$65.00 late cancellation fee. Charges are due upon request for payment.

**Missed Appointment Charge:** I will be charged a \$65.00 fee for a Missed Appointment. I am responsible for notifying SCCC. Charges are due upon request for payment.

I am aware that I am responsible for notifying SCCC of any changes in my mailing address, telephone numbers and employment.

I will notify SCCC of my decision to file insurance, know my benefits, and verify pre-certification requirements 24 hours prior to my next scheduled appointment. Proof of insurance will be provided at the time of service, or I will be required to pay the session fee at the time of visit. I will be responsible for paying my full balance should my insurance default on payment for any reason. Authorization is granted by my signature below to Sheltered Cove Counseling Center, Inc. to release to authorized representatives of my insurance company, their agents or third party payers, confidential information including copies of records as these records may be requested or necessary for the completion of claim processing and/or authorizations for future treatment. I hereby release Sheltered Cove Counseling Center, Inc. from all legal responsibility or liability that may arise from the release of such records.

If your counselor is subpoenaed to court on your behalf, the charge will be a minimum of \$300.00 (two hours including travel) and \$150.00 for each hour thereafter. If court is canceled or postponed or it is decided that your counselor's testimony is not needed without a 48 hour notice you will be charged a \$65.00 fee for each hour you have booked.

I am aware that in the event of default of payment on this account, my account may be turned over to an outside collection agency or legal representative for collection. Any additional costs incurred by SCCC to collect the outstanding balance will become my responsibility.

My signature below authorizes payment directly to Sheltered Cove Counseling Center, Inc. of the insurance benefits otherwise payable to me, but not to exceed the balance due of the charges for my treatment.

**-Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_