A Turning Point Counseling Center

OFFICE POLICIES

CONGRATULATIONS! You have already begun the process of improving the quality of your life and increasing your sense of satisfaction and well being. We look forward to being a part of this process.

CANCELLATIONS
You are responsible for remembering your appointments. We do not make reminder calls. **We will need at least 24 hours notice** if you need to cancel or reschedule. You will be charged the full session fee for missed appointments or late cancellations (i.e. less than 24-hours notice given).

LENGTH OF VISITS
Counseling sessions are 45 minutes in length but may be extended upon mutual consent. Every attempt will be made to start on time. However, if you are late, the session will end at the scheduled time.

CONFIDENTIALITY
Discussions between a therapist and a client are confidential. No information will be released from this office without the client's written consent. **Possible exceptions** to confidentiality include but are not limited to the following situations: court subpoena of records or testimony; child abuse; child custody cases; situations in which the therapist has a duty to warn or disclose information; when clients report they are in danger (emotionally or physically) to themselves or others; abuse of the elderly, disabled, or patients in mental health facilities; sexual exploitation; possible AIDS/HIV transmission; criminal prosecutions; suits in which the mental health of a party is in issue; fee disputes between the therapist and the client; collection procedures; and in a suit brought by the client against the therapist. By signing this form you are giving your consent to A Turning Point to share confidential information with other office staff, the agency that referred you and/or the insurance carrier responsible for approving and paying for your services. You are also releasing and holding A Turning Point counselors and staff harmless for any departure from your right of confidentiality that may result. **If you have any questions regarding confidentiality please ask your counselor.**

RISKS OF THERAPY
In the process of growth, you may experience and confront issues that may cause you to feel sadness, sorrow, anxiety and pain. The success of our experience together depends on the quality of the efforts made on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Each session is for provision of counseling services. **We make no guarantees of improvement and there are no refunds of session fees.**

DIVORCE DECREES
A Turning Point is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for a minor's bill rests with the accompanying adult.

CLIENTS UNDER AGE 18
Parents, guardians and adults accompanying the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless pre-authorized or paid for at the time of service.

AFTER HOURS SERVICES/EMERGENCIES
We are not a 24-hour facility and do not have emergency coverage. **In case of emergency, please call 911,** or an emergency number of your choice.

I have read and understood all the terms and information contained herein and agree to abide by them.

_____ _____

CLIENT/PARENT **DATE**

Fee Disclosure Acknowledgement

I understand and agree to assume responsibility for all fees for services rendered. Fees are due and payable at the time of service unless other arrangements are made in advance. A Turning Point accepts cash, check, debit or credit (Visa/MasterCard, Discover, American Express.)

☒ **Initial Individual, Couples or Family Counseling Session**
45 minutes = $155.00 or $_____

☐ **Regular Individual, Couples or Family Counseling Sessions**
45 minutes = $155.00 or $_____

☐ **Hypnosis Program (Stop Smoking, Weight Loss, Trauma Reduction)**
Program Cost = $_____

☐ **Alcohol and Drug Assessment- Program Cost = $_____**

☐ **Outpatient Substance Abuse Program- Program Cost = $_____**

The following is a brief, non-comprehensive listing of all services for which fees may apply.

Missed appointments or late cancellations (appointments cancelled with less than 24 hours notice) are billed for full session charges. **Telephone consultations with your counselor for purposes other than appointment setting, during or after regular office hours.**

Transfer of office records fee is $45. Drug screenings are $55. Two screenings are included in the cost of the Intensive Outpatient Program. Service charge for NSF checks is $45.00. Collection fees to recover past due balances.

Preparations of documents, letters, photo-copying and/or mailing of medical records to other counselors, physicians, attorneys, insurance companies, or other persons/agencies for employment, legal, or any other purposes.

If it is necessary to contact other professionals, represent you in court, interventions, or other out-of-office services, you are responsible for fees to cover those expenses based on time or projected time involved.

I have read and understood all the terms and information contained herein and agree to abide by them.

_____ _____
CLIENT/PARENT **DATE**

_____

Credit card information is required as security on your account:

I understand that any balance past due longer than 30 days will be charged to this credit card _____
Initial

Name on card_____ ☐Visa/MasterCard ☐American Express ☐Discover

_____ _____ _____ _____
Card Number Exp Date Security Code Signature

Communication with Client

I understand and consent to messages being left for me on my voicemail. Also, I give permission for cell phones to be used to communicate by text and/or return calls _____
Initial

I understand that faxes and emails may be sent or received on my behalf _____
Initial

I realize these forms of communication are not secure with respect to privacy of information _____
Initial

I consent for my counselor to communicate with me at the following address:

Address

In the event of an emergency, I consent for my counselor to contact:

Name **Phone Number**

Nearest relative not living with you:

Name **Phone Number**

Address

I have read and understood all of the terms and information contained herein.

_____ _____

Client/Parent **Date**

HIPAA CLIENT CONSENT

I understand that as a part of my healthcare, the therapist listed below originates and maintains health records describing my health history, symptoms, evaluations, and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provide by law.

The *Notice of A Turning Point Counseling Center* provides specific information and a thorough description of how my personal health information may be used and disclosed. I have been provided a copy of or access to this notice and I have been given the opportunity to review the notice prior to signing this consent. Before implementation of any revised practices, notice will be mailed to me at the address I used on my intake forms.

_____ _____

Signature of Client or Legal Representative Date