Lincoln Counseling Enrichment Associates

CLIENT INFORMATION FORM

COUNSELING PHILOSOPHY

Each staff member has received graduate level training in psychology. Our work often involves assisting our clients in value based decisions; we want you to know that our foundational counseling philosophy is Christian in nature. We do not intend to impose our values upon our clients, but rather to help each person use their psychological and spiritual resources to reach their goals. Please direct further questions to your therapist.

PAYMENT POLICY

Payment is to be made **in full** at the time of service. Any other arrangements must be made in advance (including post-dated checks). Testing services and educational materials are in addition to the regular fees. Our billing is administered by **Lincoln Family Medical Group, P.C.** with whom we are affiliated.

Fees are based upon 45-50 minute sessions and are as follows:

	Diagnostic Interview	Individual Session	Family Session
Suzanne Jouvenat, LIMHP	$190	$185	$155
Lynn Nagorski, LIMHP	$190	$185	$155
Jennifer Coon, LMHP	$190	$185	$155

TELEPHONE CALLS

If phone contact with the therapist becomes necessary we will try to respond as quickly as possible. Calls need to be for immediate help and not a substitute for counseling. Phone calls lasting 15 minutes or longer will be billed to the client as insurance does not cover these charges.

CANCELLATIONS - MISSED APPOINTMENTS

We must receive notice of a cancellation by noon on the business day immediately prior to your appointment. Missed appointments and late notice cancellations are subject to a charge of $75.00. _____ Initial

INSURANCE

Many insurance policies provide coverage for mental health services. If your therapist has a contract with your insurance company, your financial responsibility is limited to deductibles, co-payments and co-insurance. If your therapist is not contracted, your account will typically be your full responsibility. Please notify our office promptly should your insurance change. Failure to notify us of a change will usually result in temporary loss of coverage.

_____
Initial

CHILDREN

Children under the age of 10 are not to be left unattended in the waiting room.

CONSULTATION

We have the right to disclose selective information about your care in order to obtain payment for services (e.g. to your insurance company) unless you specifically refuse to allow us to do so. Under the same conditions we also have the right to consult with other members of the LCEA staff concerning your case to ensure the highest quality of care and to provide for emergency situations. While the law does not require you to agree to these conditions, we are not bound to provide services if you refuse to do so.

_____ Yes, you may disclose health care information under these conditions.

_____ No, I refuse to grant consent for such disclosures.

(Over)

If you are a patient of **LINCOLN FAMILY MEDICAL GROUP, P.C.,** we request permission to discuss your case with your physician.

_____ Yes, you may discuss my case with my family physician.

_____ No, you may not discuss my case with my family physician

CONFIDENTIALITY

Confidentiality of the counseling provided by this clinic is protected by law; we will not notify anyone outside of our clinic that you are receiving counseling. A **RELEASE OF INFORMATION** must be received from the client to disclose information. According to the laws of the State of Nebraska and the United States of America confidentiality may be broken:

1. If you pose a serious physical danger to yourself.
2. If you pose a serious danger to another person.
3. If you disclose that you or another person has physically or sexually abused a child, an incompetent person or a disabled person.
4. If you disclose that a child, an incompetent person or a disabled person is suffering because of neglect.
5. If there is a court order compelling us to release information.

We are required to report abuse or neglect if it is disclosed under the conditions given in (3) and (4) to an appropriate government agency.

FINANCIAL AGREEMENT/AUTHORIZATON FOR TREATMENT

I authorize treatment for the person named below and agree to pay all fees and charges for such treatment. I agree all charges for myself/members of my family will be paid promptly unless other arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. I authorize release of any medical information necessary to process my insurance claim and authorize payment of benefits to **LCEA** if my provider participates in my insurance plan.

I attest that I have read both sides of this information sheet and I understand the conditions as stated, and agree to contract for counseling under these conditions.

_____ _____

Print name of Counseling Client | Print name of Legal Guardian

_____ _____

Signature of Client | Signature of Legal Guardian

_____ _____

Signature of Witness | Date