

James Gary Fields, MA, LMFT
1111 Riverside Ave, Suite 404, Paso Robles, CA 93446
(805) 610-5059

Client Informed Consent & Financial Agreement

Date: _____ Patient Name: _____

Social Security Number: _____ Date of Birth: _____ Age _____

Home Address: _____, City: _____, State: _____, Zip: _____

Home Phone Number: _____ May we leave a message? Yes No

Cell Phone Number: _____ May we leave a text message? Yes No

If the above patient is a minor, complete the following:

Name of Guardian: _____

Guardian Address: _____, City, _____ State, _____ Zip: _____

Guardian's Home Phone: _____ May we leave a message? Yes No

Guardian's Mobile Phone: _____ May we leave a message? Yes No

Insurance

If you will be using insurance to cover your sessions or a portion of the cost please complete the following and allow us to make a photocopy of your insurance card(s):

Primary Insurance Company: _____ Office Co-Pay: _____

Secondary Insurance Company, if applicable: _____

Referral Source

Who referred you to our office, or how did you learn about our practice? _____

Emergency Contact Information

Name: _____

Relationship: _____

Address: _____ Phone Number: _____

Client-Counselor Service Agreement

Welcome! This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your counselor, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-compassion. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing or ending drug use. Whatever the goals for counseling, they will be set by you as the client according to what you want to work on. I may make suggestions on how to reach your goals but you decide where you want to go.

Risks and Benefits of Counseling

There are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to live in the present and many other advantages. Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Appointments

Appointments are 55 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The day and time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay for the session unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, he/she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, your counselor can arrange to encrypt email communication with you.

Record Keeping

Your counselor will keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity of care. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least seven years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash or credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.

Fees are negotiable. To receive sliding scale fees, please present proof of income through recent pay stubs or tax forms. Fees are subject to change at the counselor's discretion.

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Fee Schedule

Psychotherapy individual session: Initial \$150.00, Follow-up: \$125.00

Self-Pay Sliding Scale	Fee
\$30,000 or less annual income	\$50.00
\$30,001 to \$50,000 annual income	\$75.00
\$50,001 to \$70,000 annual income	\$100.00
more than \$70,000 annual income	\$125.00

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by cash, check or debit/credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.

If I am not a participating provider for your insurance plan, I will submit a claim on your behalf, but not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, please contact your insurance company for a referral.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.

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Email

At times, I may find online information that may be helpful and wish to send it to you using email. I may also use email addresses to check in with a client who has ended therapy suddenly. You have the right to not provide your email address to me. If you would like to receive correspondence through email, please provide your email address:

Email: _____

If you would like to opt out of email correspondence, please check here: _____

Consent to Counseling and Financial Responsibility

Your signature below indicates that you have read this document and agree to its terms.

Print Name _____

Client Signature _____ Date _____