COHESION INTERVENTION SERVICES

Rebecca Bullion, LCSW, CIP, SAP

COHESIONTN.COM • 615.414.2995

info@cohesiontn.com

CLIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____State: _____Zip:_____

DOB: _____SSN:_____

Phone: Home: _____ Cell: _____ Work: _____

Which # do you prefer to be contacted? _____

May we leave a message? _____

Emergency Contact Person:

Name: _____ Phone: _____

Relationship: _____

How were you referred to this office: _____

Fees:

Fees for service are $125.00 for the first session and $100.00 thereafter. We are in-network with some insurance companies. Please provide insurance card at time of intake for copying. Also, please call insurance company prior to intake to check deductible, copays and precertification requirements.
Payments for service can be made via check, cash, or card.

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ISSUES • SYMPTOMS

Please check issues that you have been experiencing in the past 6 months:

- ☐ **Depression**
- ☐ **Grief/Loss**
- ☐ **Anxiety**
- ☐ **Eating disorder**
- ☐ **Substance Abuse**
- ☐ **Substance Dependence**
- ☐ **Other addiction**
- ☐ **Job related problems**
- ☐ **Sleep problems**
- ☐ **Health related problems**
- ☐ **Educational problems**
- ☐ **Relationship problems**

Please clarify briefly for any of the checked items:

_____

_____

_____

_____

_____

Please indicate any other information, which you would like to be known prior to initial appointment.

_____

_____

_____

_____

_____

_____

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Payment Policy

Please review this notification and sign below to indicate that notification has been received.

Sessions are 50 minutes each.

No-show fee applies if less than 24 hours is given for canceling session. This does not apply to sickness.

Payments for service are due at time of service. Payments may be made via check, cash or credit card. Receipt provided upon request.

It is our aim to not allow balances to accrue. If a balance is left outstanding for more

than 60 days, it may be sent to a collections agency. In this incidence, a collection fee of $300.00 per case for all collection attempts for time incurred. Additionally, a fee of 3%

of entire balance will be added per month. Collection agency fees will also be the responsibility of the client to reimburse.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

If you wish for us to keep a credit card on file for convenience, please indicate by completing the information below. Credit card information is disposed of after completion of counseling.

Card Type:_____ Card #: _____

Exp. Date:_____ Security Code: _____

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Psychotherapy Disclosure

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HlPAA), 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.

THERAPY SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, 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. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing unconformable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen.
Psychotherapy 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.

PROFESSIONAL FEES

The standard fee for the initial intake is $125.00 and each subsequent session is $100.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; I am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and 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.

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INSURANCE CONTINUED…

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some eases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. 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 therapy fees. If you did not obtain authorization and it is required, you may he responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called coinsurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. 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. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract. If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

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PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices [See Samples on FORMS page]. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at anytime during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless she/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. [See sample Adolescent Consent Form, to be signed by both adolescent and parent(s)].

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. voicemail and your call will be returned as soon as possible. If you feel you cannot wait for a return call or if you feel unable to keep yourself safe: 1) ***Contact the Crisis Line at 615-244-7444***
2) ***Go to your Local Hospital Emergency Room***, or 3) ***call 911 and ask to speak to the mental health worker on call***. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

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OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ _____

Signature of Patient of Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____ _____

Therapist Signature Date