Notice of Privacy Practice

Client Information and Acknowledgement of Informed Consent to Treatment & Fees Form

Receipt and Acknowledgement

Client Name: **DOB:**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of HRS Counseling Services, LLC's Notice of Privacy Practices and Client Information and Acknowledgment of Informed Consent to Treatment Form. I understand that if I have any questions regarding either of the named documents, I can contact my therapist at the above contact information.

Signature of Patient/Client Date

Signature or Parent, Guardian or Personal Representative* Date

**If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

☐ ***Patient/Client Refuses to Acknowledge Receipt:***

Signature of Counselor Date

Statement of Fees

Receipt, Acknowledgement of Notice & Agreement to Pay Services

HRS Counseling charges a fee for providing services. HRS is an ***OUT OF NETWORK PROVIDER***:

(Please initial each section signifying that you have read it, understand it, and have no questions)

Rates ______

- Our standard rate for individual counseling is $100 per **session< 52 mins;** $135 for **session > 53 mins**.
- Diagnostic Evaluation $125 per session
- Couples counseling $120/$160 per session
- Family counseling $150 for a single therapist and $200 for two therapists. The primary therapist reserves the right to determine if more than one counselor is needed in a family session.
- All documentation requests will be charged by the hour/or part of the hour $25
- Continual conversations via phone that last longer than 10 mins will be charged $25 any part of the quarter hour utilized.
- Same day Crisis Appointments are $125/38 min session
- Off Site Sessions are $125/ $166 per min session
- Court Costs: $300/hour including but not limited to: prep work, travel time, court time, interviewing, etc…
- Each person is responsible for paying amount at session or credit processing will be utilized

Insurance ______

- HRS Counseling Services and its associated therapists do not submit payment requests to your insurance company. However, we will provide the information you need to submit requests directly. Please let your therapist know if you need documentation in order to file an insurance claim.

- All SUPER BILLS will contain your clinical diagnosis that you can submit to your insurance. In addition, at times HRS will be requested to submit clinical information to your insurance company. This information will become part of the insurance company files and will probably be stored on a computer. Though all insurance companies claim to keep such information confidential, HRS Counseling, LLC has NO control over what they (Insurance Co.) do with the information. If you choose to submit your Super Bill to your insurance company you are permitting HRS Counseling Services, LLC to release in written and verbal communication forms the documented information on the form to your Insurance Company.

Payment______

- All clients will pay balance at time of service.
- As a courtesy, we provide reminder notifications for your appointments. However, should you not receive this notification for any reason; you remain responsible for your appointment date and time.
- All clients are responsible for the full payment of any fees (including bank/late charges) in addition to a $25 fee for insufficient funds.

Credit Card Guarantee/Permission______

I___________________ am voluntarily offering this credit card guarantee in the event that I neglect to pay my fees or do not cancel my appointment with giving a 24 hour notice or for any other reason payment for services is not made. I am authorizing HRS Counseling Services, LLC to bill my credit card for any outstanding balance due including missed appointments and late fees all of which are noted in this document.

CARD #________________________________ EXP:______ SEC Code: _______ Zip Code: ________________

SIGNATURE: ____________________________DATE: ____________WITNESS_________________________

Client Acknowledgement _______

I hereby acknowledge that I am personally responsible for the fees charged for receiving services. I understand that insurance claims are submitted by me utilizing the "Super Bill". I also understand that I must give a 24 hour notice of cancellation fee for failing to attend an appointment I have made or I will be charged for my scheduled appointment.

Texting _____

I understand that texting with the therapist is not HIPAA compliant and that HRS Counseling Services, LLC is not responsible for the protection of your personal health information if you choose to communicate via text.

Minors _____

I understand that my Minor in therapy will be discussing information that I am not privy to. I understand that the only information that will be discussed with me will be that stated under the "Duty to Protect" nature of this document. I understand that Holly St.Pierre MS Ed LPCC is not permitted to give opinions towards custody or visitation purposes in court. All clients will be taught healthy boundaries in therapy sessions: including but not limited to… internet, peer, stranger, interpersonal relational, trafficking awareness

Litigation _____
Holly St.Pierre MS Ed LPCC with HRS Counseling Services, LLC reserves the right to refuse attending litigation. Therefore, If subpoenaed by your attorney/counsel my financial rate per hour of $300 including but not limited to: travel time, preparation time, court time…anything in relation to the case.

Incapacity or Death_____
I give my consent to allowing another licensed mental health professional selected by HRS Counseling Services, LLC to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Square Receipt_____
I give my permission to allow HRS Counseling Services to utilize SQUARE Receipts with my (client) CPT codes and personal information.

Consent to Treatment _____
I, voluntarily, agree to receive mental health care, treatment, or services and authorize my therapist to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through HRS Counseling Services at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgement of Informed Consent to Treatment & Fees Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name____

Client Signature____ DATE: _____________________________________

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Parent or Guardian Signature (for minor child) (DATE)

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Witness Signature (DATE)