

WELCOME TO LANIER COUNSELING SERVICES!

(Please indicate your agreement by providing your initials for each section. Thank you.)

- _____ Please take a few moments to read and complete the following forms. We want to thank you for choosing our practice. Together we will work to identify and implement solutions to the problems that brought you here. All sessions are 50 minutes in length. In the first session, we will discuss the presenting problem through mutual questions and answers. We will identify possible goals and discuss follow-up sessions. We will review any questions you have about your rights and responsibilities as a client and clarify financial arrangements. Please feel free to ask any questions at any time in our work together.

- _____ Therapy is a personal experience. Although there are no guarantees, potential benefits include not only a greater ability to handle or cope with problems and interpersonal relationships but also a better understanding of personal goals and values. You may trust that what is discussed in therapy is confidential. Exceptions to confidentiality are as follows: (1) disclosure of a serious intention or plan to harm another person. All therapists are required by law to warn the intended victim and report it to the legal authorities; (2) disclosure of a serious plan or recent attempt of suicide. All therapists are required to notify the family of the client and/or legal authorities; (3) If a court of law issues a legitimate subpoena. (4) Disclosure of any information suggesting abuse/neglect of a child or vulnerable adult. All therapists are required to notify the legal authorities; (5) If a minor discloses a plan to run away, family will be informed as well. All other communications require your authorization.

- _____ If you use a third party payment, a diagnosis is given to the insurance company for reimbursement. The insurance company also has the right to review your records upon request. We have no control over how your insurance company uses or releases your diagnosis or other information.

- _____ Our goal is to meet only as often as needed to resolve the problem. There is no charge for brief phone calls. We do not take phone calls between sessions, except for emergencies. We DO NOT have 24-hour coverage. Therefore, after hours and weekend emergencies necessitate the use of the local emergency rooms or psychiatric hospitals.

- _____ 24 Hour Advance Notice is required and 48-Hour notice is appreciated to cancel or reschedule appointments. You are responsible for paying for missed appointments. Please leave a message on our confidential answering machine (available 24-hours a day) if you are unable to get in touch with us directly. You will be charged in full if 24-hour advance notice is not given.

- _____ We bill your insurance as a courtesy to you and accept co-payment while awaiting reimbursement. Any insurance claim not paid within 30 days will be billed to you. All returned checks will be charged a \$20 fee and need to be paid within 7 days of return from the bank.

- _____ Lanier Counseling Services focuses on therapeutic issues. We believe in most cases that our involvement in the legal system is counterproductive to therapy. Furthermore, our therapists are not trained to complete custody evaluations. However, if at any point a subpoena is received, our fees are \$275.00 an hour for all legal involvement related to the subpoena including any preparation, phone calls and transportation.

- _____ I acknowledge reading a copy of the Notice of Privacy Practices (HIPPA) for Lanier Counseling Services.

Printed Name: _____ **Date:** _____

Signature: _____

Client Insurance and Billing Information
(Please present insurance card to be copied by provider)

Client(s) Information (person / persons we will be seeing)

Client Name(s) _____ DOB: _____
(individual or couples names) _____ DOB: _____

Client Address: _____

City/State/Zip: _____ Home Phone #: _____

Client Social Security Number: _____ Wk/Cell Phone #: _____

PRIMARY INSURANCE INFORMATION (person that holds the insurance policy)

Name of Insured: _____ Insured's DOB: _____

Insured's Address _____ Home Phone #: _____

City/State/Zip _____ Cell Phone #: _____

Name of Insured's Employer _____ Work Phone #: _____

Relationship to Client (please circle one): Self Spouse Parent Other

Insured's Social Security number: _____ Insurance Policy #: _____

Insurance Company Name: _____ Group #: _____

Ins. Mental Health Phone #: _____ Authorization #: _____

_____ Please Note: Insurance companies often require clients to obtain preauthorization before the first appointment. You are responsible for obtaining the initial authorization. Before you are seen for the first appointment we must have the authorization information (i.e. authorization number and/or letter) given to you by the insurance company as well as a copy of your insurance card. We suggest that you confirm your outpatient mental/behavioral health benefits (deductible, co-pay, which providers in our office are covered, etc.) before arriving for your first appointment.

_____ I have read and agree to all payment and policies of LCS. I acknowledge that I am responsible for all charges whether or not insurance pays. I hereby assign all medical benefits to LCS and acknowledge that a photo copy of this assignment is valid as original. **I understand that insurance companies do NOT pay for missed appointments.**

_____ I authorize LCS to release confidential information regarding my treatment and diagnosis to my insurance company or managed card program.

Patient Signature (or Legal Guardian)

Date

Date: _____

Name: _____ Date of Birth: _____ Age: _____ SS#: _____ - _____ - _____

Address: _____ Home #: (_____) - _____

City: _____ St.: _____ Zip: _____ Cell #: (_____) - _____ Wk#: (_____) - _____

Highest Level of Education: _____ Occupation: _____

Marital Status: Single Married Separated Divorced Widowed Living together as a couple

Name of Legal Guardian (if client is under 18): _____ Legal Guardian's Relationship to Client: _____

Name of Emergency Contact: _____ Emergency Contact Phone #: (_____) - _____

How did you hear about Lanier Counseling Services? _____

Have you had any prior counseling, psychological or psychiatric treatment? Yes No

If Yes When? _____ With Whom? _____

Who is your Primary Care Physician (PCP)? _____

PCP Phone #: (_____) - _____

Are you currently taking any medications? Yes No

If "Yes", please list all medications relevant to therapy:

Date of last physical exam: _____

Do you have any medical conditions relevant to therapy? Yes No

If "Yes" Please list them:

What is the primary reason you are seeking counseling?

How long has this problem persisted? _____

What would you like to get out of counseling?

I am currently experiencing:	I have a history of:	Problem Categories "X" all that apply - circle primary
_____	_____	1. Alcohol
_____	_____	2. Drugs (specify)
_____	_____	3. Emotional Problems
_____	_____	4. Marital Problems
_____	_____	5. Family
_____	_____	6. Physical Health (specify)
_____	_____	7. Another's alcohol or drug
_____	_____	8. Another's emotional health
_____	_____	9. Legal/Financial Problems
_____	_____	10. Other (specify)

Level of severity (How much do these problems bother you?)
 Minimal Mild Moderate Severe Extreme

REGARDING INSURANCE

(Please indicate your agreement by providing your initials for each section. Thank you.)

_____ Please allow us to educate you about using your insurance Mental/Behavioral Health benefits. If you choose to use your insurance for counseling, you must contact your company prior to your first visit. Not necessarily Lanier Counseling Services, but the individual counselor you want to see will have to be an approved provider for your particular insurance company. This is no different than the doctor you see for your major medical benefits. Give us a call (770-271-9442) and we can share that information with you. Not all of our counselors accept the same insurance. Most insurance companies will want to pre-authorize a number of sessions. Please bring with you your insurance card, the information regarding number of approved sessions, and the "Authorization Number" they provide you. Please remember, it has been our past experience, that occasionally even with the prior-approval and an Authorization Number that some companies may still reject the claim. Their statement is that Authorization does not guarantee payment. The agreement you have with the insurance company is an agreement among the two of you. Your bill with Lanier Counseling Services is ultimately your responsibility, regardless of their actions. You may very well be required to first meet an annual deductible, and have a co-pay amount due at each session.

_____ As a reminder, we want to alert you that many times utilizing your Mental/Behavioral Health Insurance benefits is like having a third outside party in the room with us while you discuss sensitive topics. They reserve the right at any time to review our notes about things you discuss in order to justify the claim. The insurance company will also require us to provide a diagnosis for you or a family member from the Diagnostic and Statistical Manual of Mental Disorders. Clinically and ethically we must provide accurate coding. This information becomes part of the insurance company file and may be reported to a national medical information data bank. We cannot foresee how this diagnosis may impact you in the future in regard to disclosure on items such as life insurance applications, other health insurance applications, or applications for a number of other items. It is for these reasons that we keep our rates competitive and many clients bypass their insurance and pay out-of-pocket. This way, we are bound by confidentiality (except to be released as required by law) and can not disclose to others unless you inform them and authorize releases of information.

_____ We will work with your insurance company as a courtesy to you. The bill remains your ultimate responsibility. If your insurance company is slow to pay (in excess of two months) or does not pay, we will look to you for payment in full.

_____ If at least 24 hours notice is not given, you will be charged for missed appointments. This fee cannot be billed to your insurance. Unfortunately true emergencies arise. We will depend on your honesty and work with you if at all possible.

Printed Name: _____ **Date:** _____

Signature: _____

STIPULATION FOR COUNSELING

In order for counseling to be effective one must be open, honest, and self reflective. When there is a possibility of litigation (legal/court actions, separation/custody/divorce proceedings, disability applications, etc.), this process is severely compromised and becomes ineffective. The tendency is for one to present themselves in a better light, depending on desired outcome, while highlighting the negatives attributed to another party or situation.

Counseling cannot be effective when these dynamics occur. There can be no therapeutic gain when the discourse becomes slanted and self-serving. I (we) agree to waive all rights to subpoena and/or to otherwise use Lanier Counseling Services, its therapists, its files and records, or the counseling process in any and all current and/or future litigation and/or court actions.

Signature

Signature

Printed Name

Printed Name

Date

Date