



Inner Peace Counseling

INFORMED CONSENT

Client Name: _____ DOB: _____ SS #: _____

Thank you for choosing Inner Peace Counseling. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of office policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

I, Linda J. Stockton, earned a Bachelor of Arts Degree in Personnel from Purdue University (Fort Wayne, IN) and a Masters of Arts Degree in Counseling from Marshall University Graduate College (South Charleston, WV). I am a Nationally Certified Counselor, a Certified Clinical Mental Health Counselor, a member of the American Counseling Association and I am a Licensed Professional Clinical Counselor (Ohio). I have clinical experience in treating individuals age 10+, adults, couples/dyads, families and groups.

For most conditions I primarily use Cognitive-Behavioral Therapy (looking at the importance of your thoughts in how you feel and what you do), though I frequently draw from other theoretical frameworks as well depending on the person or situation. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY & EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for:

- information used to treat you, run my company, share with your insurance company to process your claims (optional), or Employee Assistance Program (EAP) benefits (optional);
- information you and/or your child(ren) report about child abuse or elder abuse; then, by Ohio State Law, I am obligated to report this to the Department of Children and Family Services or appropriate authorities;
- if you provide information that informs me that you are in imminent danger of harming yourself or others;
 - Do you possess gun(s)/weapons? Yes__ No__; What type? _____
 - Do you have a license for gun(s)? Yes__ No__ Where are they kept? _____
 - Emergency contact name/phone: _____
- where you sign a release of information to have specific information shared;
- information necessary for consultation, case supervision or to address workers' compensation and other Government requests
- defense of malpractice or professional complaint
- collection of debt per Financial/Insurance Policies on Page 2
- when required by law or by court order.

If you have an emergency or are in crisis, you or your parent/guardian are to call 911 or go to the nearest emergency room. Do NOT call me first. I will be available to follow up emergency services with standard counseling. If an urgent non-life-threatening situation for which you or your parent/guardian feels attention is necessary before your next appointment, please call the office at 567-525-5615; after business hours call my cell phone at 419-722-2032. Please note that conversations made on a cell phone are not confidential. There is no charge for calls lasting less than 15 minutes. I do not utilize email or text messaging to communicate with clients or parents/guardians; emails and texts are not confidential.

Client Signature

Date

Parent/Guardian Signature (if client < age 18)

Date

FINANCIAL/INSURANCE POLICIES: IF YOU PLAN TO UTILIZE INSURANCE, it will be important that we are able to verify your benefits prior to your appointment or you will be expected to pay the entire fee and wait for me to reimburse you if/when your insurance plan pays me. YOUR SHARE OF THE FEE (e.g., co-pay, co-insurance, deductible) IS EXPECTED IN FULL AT THE BEGINNING OF YOUR SESSION. I am considered an in-network provider for some insurance plans and out-of-network provider for others. PAYMENT IN FULL IS EXPECTED AT THE BEGINNING OF YOUR SESSION FOR SELF-PAY/CASH clients unless we have signed a fee waiver. I accept cash, checks and credit/debit/HSA cards. My billing service, Electronic Medical Claims Consultants (EMCC), verifies insurance coverage and files your claim with both your primary and secondary insurance plans. Please contact EMCC directly regarding insurance and billing questions or concerns at 1-614-401-3024.

When the client is a minor and the parents are estranged, divorced or legally separated, the policy is to designate the person who initiated counseling to be the Guarantor. I am not able to bill each person for his/her "share" of the costs as designated by the divorce decree or other legal document. The expectation is for the person who initiated counseling to be responsible for the bill and to gain any reimbursement from the other parent.

In the event of non-payment after several warning letters, Inner Peace Counseling may utilize a collection agency of its choice to secure payment and/or take you to small claims court. By signing this page you waive your right to confidentiality of any information needed to pursue collection of your entire account balance through these methods.

FEE SCHEDULE EFFECTIVE 01/01/16:

CPT Code	Professional Service	Fee*
90791	Psychiatric diagnostic evaluation/intake assessment	\$150
90837 & 90839	Psychotherapy/psychotherapy for crisis, 60 min. w/patient &/or family member	\$200/\$240
90849	Multiple-family group psychotherapy, 60 minutes	\$150
90834	Psychotherapy, 45 minutes w/patient or family member	\$100
90846 & 90847	Family psychotherapy/conjoint psychotherapy with/without patient present, 45 minutes	\$120
90840	Psychotherapy for crisis add-on for each additional 30 minutes of psychotherapy used in conjunction with code 90839	\$ 75
90832	Psychotherapy, 30 minutes w/patient and/or family member	\$ 50
90853	Group psychotherapy (other than multiple-family group), 60-90 min.	\$ 50
90785	Interactive complexity add-on code used in conjunction with codes for primary service: 90791, 90832, 90834, 90837 and 90853	\$ 50
	Phone consultations 16 minutes or longer (first 15 minutes are free) – not covered by insurance	\$ 25/15 min.
	Late Cancellation /Missed Appointment/No Show (See Policy Below)	\$ 50
	Returned check fee for NSF (non-sufficient funds)	\$ 25
	Fee for replying to subpoena, court testimony, depositions, travel miles/time portal to portal, wait time, my attorney fees, and time spent in preparation; this is regardless of action/outcome	\$120/hr. + expenses

*If I am an "in-network" provider, I am under a contractual agreement with that insurance company and am required to adhere to their fee schedule (not to exceed the fees posted above). Typically this means I write off part of my fee in exchange for being in their network. However, if I am an "out-of-network" provider, I am permitted to "balance bill" or collect from the client the portion of my fee not covered by insurance, not to exceed the fees posted above.

*To reflect my core values, I set aside 10% of my case load for pro bono (free) services upon request on a first-come-first-served basis and for a limited number of sessions. Pro bono appointments may be restricted to non-peak hours (before 3:00 p.m.) and require execution of a "Fee Waiver" with my signature prior to delivery of service(s).

Late Cancellation/No Show Policies: Cancellation of an appointment is expected no later than the calendar day prior to the scheduled appointment by calling my office (not my cell phone) at 1-567-525-5615 and leaving a voice mail message. Failure to do so will result in a \$50.00 "late cancellation" fee NOT covered by insurance. Failure to call or show up for a scheduled appointment will result in a \$50.00 "no show" fee NOT covered by insurance. In the case of inclement weather, only you can decide if you can safely drive to your appointment; however, failure to show for your appointment due to weather will still be subject to the "no show" fee unless a Level III snow emergency is in effect. In the event I cancel your appointment with less than 24 hours' notice to you, I will provide you with a coupon that waives one future late cancellation/no show fee that you might otherwise incur.

Client/Responsible Party (Parent/Guardian if client <18)

Date

COORDINATION OF TREATMENT/CONTINUITY OF CARE:

If you want your health care providers to work together, I need your written permission to communicate with your primary care physician, OB-GYN and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time; however, a revocation is not valid to the extent that I have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

___ I decline to inform my physician and/or psychiatrist.

___ Yes, you may inform my physician(s).

Information to be shared (check all that apply):

- ___ 1) Social History/Intake Summary
- ___ 2) Psychological tests and evaluations
- ___ 3) Education-Vocational assessments
- ___ 4) Verbal/written reports from counseling sessions
- ___ 5) Alcohol/substance abuse&/or dependence issues
- ___ 6) Treatment issues
- ___ 7) Diagnosis
- ___ 8) Compliance
- ___ 9) Other _____

Physician/Name: _____ Clinic: _____

Address: _____

Phone: _____ Fax: _____

Client Signature _____ Date _____

Parent/Guardian Signature (if client < age 18) _____ Date _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

Yes No I/We have read and received a copy of the Notice of Privacy Practices (HIPAA) & Client Rights documents.

Please indicate which of the following is/are acceptable forms of communication (including leaving messages):

Yes No Contact you by phone? _____

Yes No Contact you at home mailing address? _____

If no, contact you at (other)? _____

Client Signature _____ Date _____

Parent/Guardian Signature (if client < age 18) _____ Date _____

PROVISION TO AVOID ABANDONMENT:

In the unlikely event that I, Linda J. Stockton LPCC, am unable to provide ongoing services (e.g., disability, death, etc.), Barbara V. Williamson LPCC, will become the custodian of my records. She will contact you and offer to either provide subsequent counseling services or assist you in finding a new therapist in your insurance network and then forward your file to him/her. Barbara Williamson can be reached by phone at Stepping Stones Counseling Center 1-419-422-7970.

DURATION OF COUNSELING RELATIONSHIP:

If three (3) months lapse without your making and keeping an appointment, I will assume you are no longer interested in participating in counseling with Inner Peace Counseling and will close your chart (move it to inactive status), thus ending our counseling relationship. If you want to resume counseling at some point, please call my office to discuss setting an appointment for a new intake assessment.

Client Signature _____ Date _____

Parent/Guardian Signature (if client < age 18) _____ Date _____

CONSENT FOR TREATMENT OF CHILD OR ADOLESCENT < AGE 18:

I/We consent that (child's/adolescent's name) _____ may be treated as a client by Inner Peace Counseling.

A limited number of appointments are available after school hours; however, at times it may be necessary to schedule appointments during school hours. Upon request, Inner Peace Counseling will provide a signed form stating the date and time the client had an appointment.

This consent to treat expires: a) at the end of treatment; b) when revoked in writing by the parent(s)/guardian(s) who initiated treatment; or c) when the child turns 18.

Client Signature

Date

Parent/Guardian Signature (if client < age 18)

Date