**INDIVIDUAL AND FAMILY THERAPY**
**FEE INFORMATION**

**Fees for individual and family therapy will be the following:**

| | |
|---|---|
| Intake Session: | $160.00 |
| Therapy Session: | $130.00 |
| Resident Therapist (non-licensed): | $80.00 |

**Fee for missed session or late cancellation:**

$130.00

**Fee for attendance at court proceedings:**

$130.00 per hour beginning when I leave my office

Travel expenses are in addition to the hourly rate.

**Fee for special research**:

$130.00 per hour

**Fee for written reports for courts, disability applications or schools:**

$130.00 per hour

**NOTICE** FAILURE TO PAY YOUR FEE MAY RESULT IN THE BILL BEING FORWARDED TO A COLLECTION AGENCY. IF YOUR OUTSTANDING BILL IS FORWARDED TO A COLLECTION AGENCY, A SURCHARGE OF 40% WILL BE ADDED TO THE AMOUNT YOU OWE.

Stribling counseling services, Inc.
"Strength comes from within"

## CLIENT INFORMATION

Client Name: _____ Today's Date: _____/_____/_____

DOB: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____ Male: _____ Female: _____

Client Address: _____City:_____State:_____Zip:_____

Home Phone: _____Work: _____Cell:_____

Client Email:_____

Parent/Spouse Name:_____ Email:_____

Home Phone: _____Work: _____Cell:_____

Emergency Contact Name:_____ Email:_____

Home Phone: _____Work: _____Cell:_____

## INSURANCE INFORMATION

Policy Holder: _____DOB:_____/_____/_____Social Security #:_____-_____-_____

Male:_____ Female:_____Relationship to Client:_____

Insurance Co. Name: _____ ID:_____ Group #:_____

Insured's Employer: _____Phone:_____

## FEE POLICY

The fee for an initial visit is $160.00. The fee for each session following the first session is $130.00. For clients covered by insurance, I recognize that there are many different plans. Some insurance companies require that the client pay a co-payment for each session. Other insurance companies vary in the amount they pay for the session. In some cases, clients are responsible for the balance not covered by the insurance. All financial obligations need to be paid at the time of service. I acknowledge receipt of a copy of the Fee Policy and agree to the terms specified within. I also authorize release of information necessary to process claims (including those covered by Federal Regulation 42CFR Substance Abuse) and authorize payment directly to Stribling Counseling Services, Inc.

Fee schedules are reviewed annually and changes are made if necessary. Clients will be notified of fee changes.

## CANCELLATION POLICY

There will be a charge of $130.00 for appointments that are not kept and for cancellations that occur less than 24 hours prior to the appointment. Please sign below to acknowledge understanding of the above information and consent for treatment.

_____ _____/_____/_____
Signature of Client or Authorized Person Date

## CONFIDENTIALITY STATEMENT

With few exceptions, the National Association of Social Workers protects your confidentiality through the Workers Code of Ethics and Virginia State law. The following circumstances are the most common situations that do not protect your confidentiality:

1) If you make statements that I determine to be a serious threat to harm yourself or other person(s), I am required by law to protect you or the other person(s). I will act in whatever way my professional judgment determines necessary to keep you or others safe including reporting this to the proper authorities.

2) If I suspect or believe that a child or elderly person has been or will be abused or neglected, I am required by law to report this to the proper authorities.

3) If the court has sent you to me for treatment, the court expects a report or reports from me. If you are in that situation, please discuss this with me. You have the right to tell me only what you choose to disclose.

4) If you are a party involved in a lawsuit or has been charged with a crime, I may be ordered to show the court my records. This can occur if you disclose to the court that you are in treatment with me. It is best to consult your lawyer if these circumstances apply to you.

_____ _____

Signature of Client or Authorized Person Date

## CLIENT BILL OF RIGHTS

YOU HAVE THE RIGHT TO:

- Respectful treatment that will be helpful to you
- A safe treatment setting that is free from sexual, physical and emotional abuse
- Report unethical or illegal behaviors by the therapist
- Request and obtain information about a therapist's qualifications that include his/her license, education, training, experience, membership in professional groups, special areas of practice and limits on treatment
- Know about the conditions of therapy that includes fee, cancellation policies, appointment times and privacy issues
- Refuse video/audio taping of sessions
- Refuse to answer any questions or give any information that you do not choose to provide
- Know if your therapist will discuss your case with others for staffing purposes
- Request that the therapist inform you of your progress

_____ _____

Signature of Client or Authorized Person Date

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## ELECTRONIC AND TELEPHONE CONTACT PERMISSION FORM

Communication that is transmitted over the telephone, internet or stored on external voicemail devices (voicemail on our cellphones for example) is not secure or confidential. While it is rare, there is always the possibility that someone working for the telephone company or email provider will access your information. Because the information cannot be guaranteed secure we need your permission to contact you by phone or email. If you are concerned about the content of any communication being read or listened to by someone other than our staff, you have the right to limit our contact with your through those forms of communication. We will not communicate detailed clinical information via email, text, or voicemail.

Please **INITIAL EACH LINE** for the form of communication you authorize Stribling Counseling Services, Inc. (SCS) to use to contact you. (Contact details are listed on the Intake Form)

Client:

_____ Cell _____ Home _____Work _____Text _____Email

Parent/Guardian: Name_____

_____ Cell _____ Home _____Work _____Text _____Email

Parent/Guardian: Name_____

_____ Cell _____ Home _____Work _____Text _____Email

_____ When leaving a voicemail SCS can only leave name and telephone number

_____ When leaving a voicemail SCS can leave a detailed message

_____ In case of emergency, I authorize SCS to contact _____

at (____) _____-_____ OR _____

at (____) _____-_____

_____ _____ _____

Name of Client (printed) Signature of Patient/Parent/Guardian Date

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## CONSENT TO TREATMENT

I acknowledge that I have received and read copies of the Client Bill of Rights, Confidentiality Limitations and Fee and Cancellation Policies. I have had my questions answered fully.

I understand that by signing this consent, I, _____(client), agree to participating in treatment. I recognize that developing a treatment plan with this therapist and timely review of the work toward meeting treatment goals and objectives are in the best interest of the client.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I can stop treatment with this therapist at any time. I will remain responsible for payment of services already received. I understand that if I stop services before planned treatment is completed, the client may have unresolved issues to deal with on his/her own.

I know that I must call to cancel an appointment at least 24 hours before the scheduled time. If I do not cancel or appear for the appointment, I will be charged for the appointment. I also understand that my insurance will not cover the above described fee.

I am aware that an agent for my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of the services or treatments I receive. I understand that if payment for the services I receive is not made, the therapist may stop treatment.

My signature indicates that I understand and agree with all these statements.

_____ _____
Signature of Client or Authorized Person Date

_____ _____
Witness Date