Serenity Counseling Services

"Finding a Balance Along Your Journey in Life"

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REGISTRATION/CONSENT

Name: _____Email: _____

Address: _____ City, State, Zip: _____

Home Phone #: _____ Cell Phone #_____ Work Phone #_____

May we call you at ☐ Home ☐ Cell ☐ Work ☐ All Do you want a reminder ☐ Call ☐ Text

Gender: ☐ M ☐ F ☐ Other ☐ Prefer Not to answer

DOB: _____ Under 19 yrs of age? ☐ Yes ☐ No If Yes what is your current age? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Cohabitating ☐ Other

Patient employed by: _____ Spouse/Parent Employed by: _____

If full/part time student what school do you attend? _____

In case of emergency notify: _____/_____/_____
Name Relationship Phone #

How did you hear to this office? _____

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INSURANCE AGREEMENT: Serenity Counseling will bill your insurance company regardless of network status, however the client understands that some insurance policies do not provide benefits for outpatient mental health treatment. The client therefore assumes full responsibility for the payment of all charges incurred during the course of their treatment. As a client of Serenity Counseling you grant your permission for any payment under the medical insurance program be made to the provider on any bills for services rendered. By providing your insurance information (a photocopy of insurance card is also accepted) you hereby authorize communications and disclosures to the persons or entities indicated below, and their agents and representatives:

PRIMARY INSURANCE:

_____ Company Name	_____/_____ Name of Policy Holder DOB	
_____ Company Address, City, State & Zip	_____ Address of Policy Holder	
_____ ID #/Group #	_____ Clients relationship to Policy Holder	

SECONDARY INSURANCE:

_____ Company Name	_____/_____ Name of Policy Holder DOB	
_____ Company Address, City, State & Zip	_____ Address of Policy Holder	
_____ ID #/Group #	_____ Clients relationship to Policy Holder	

*Please note that the client (or guardian of client) is responsible for the bill. This office will NOT bill another party. If you have a custody agreement or other arrangements for payment it is up to you to obtain payment and forward to Serenity Counseling.

FINANCIAL AGREEMENT

- As a client of Serenity Counseling you agree to all financial obligations incurred. Your insurance will be billed for you. It is your responsibility to provide a copy of a current insurance card and notify this office if there are any changes. **You are also responsible for any co-pay or deductible amounts due for services.** Co-pays are due at the beginning of each session. Private pay sessions are due at the time of service. Accepted forms of payment include Paypal, cash or credit/debit. NO CHECKS ACCEPTED.
- You are responsible for any co-pay and yearly deductibles based on your insurance. If there is not current insurance information on file with Serenity Counseling and the claim is denied you are responsible for the entire payment. Please update the office with any changes to insurance information ASAP.
- This office understands that there are times when insurance does not cover the entire cost of counseling and that can create a hardship for the client. Serenity Counseling is willing to work with clients on a sliding fee scale that is feasible for the client based on their income and reviewed every six months. If you are on a sliding fee scale you will be provided with a Sliding Fee Agreement.
- If you are unable to keep your appointment time you are expected to contact Serenity Counseling by phone, text or email to cancel or reschedule your appointment within 24-hours. It is important to be able to offer your unused time to another client. A $25.00 fee is assessed for appointments which we do not receive a notification of cancellation/rescheduling within the 24-hour time frame. Insurance DOES NOT cover this fee. Exceptions are made for weather related cancellations and illness of client with documentation if call is made prior to appointment time.
- Accounts that are not paid within six months of the date of first notice will be turned over to collections. These accounts will be assessed a 15% collection fee to the total. Information that will be provided to the collection agency for payment is your name, address, phone number and amount owed for services rendered.

CLIENT'S BILL OF RIGHTS/RESPONSIBILITIES

- Counseling with this office is **VOLUNTARY**; you have the right to discontinue at any time without penalty or prejudice. If you decide to discontinue counseling with this office your decision will be respected. It is asked that you let the therapist know if you have a scheduled appointment that you will not be attending so that time can be offered to another client
- You have the right to receive the proper time allowed for a counseling session. Average counseling sessions are 45-50 minutes in length. If the session prior to your scheduled appointment has run over due to an emergency the therapist will let you know as soon as possible, whereas you will have the option to wait or reschedule your appointment. You understand at times this may happen due to the nature of mental health counseling and will not hold this against the therapist
- You have the right to be free from any discrimination based on age, sex, race, religion and/or sexual orientation.
- You have the right to have other people join you in counseling if this is part of your healing process. HOWEVER, these individuals will be required to sign confidentiality forms and will be held to the same requirements of the client. Minors are NOT allowed in other individual's sessions (except family sessions) without the written consent of their parent(s)/guardian PER session attended.
- You have the right to have an adequate explanation of forms and have all questions answered prior to signing such forms. You also have the right to be fully informed of all charges including those services that are not covered by your insurance company.

- You agree to attend counseling sessions as scheduled. If you are not able to make your appointment it is expected that you notify the office of cancellation. If you are scheduled in a regular weekly time slot and you miss your appointment without notification you **WILL NOT** be scheduled for the next week until you contact this office. This may result in you losing that regular time slot. If you reschedule the regular time slot three (3) consecutive weeks you may also be subject to losing your regularly scheduled time slot.

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TERMINATION OF TREATMENT:

- The status of any person as a client with Serenity Counseling may be terminated whenever it is determined that patient has failed, neglected or refused to cooperate with the therapist in its efforts to treat such client. Clients have the right to terminate treatment without cause at any time. As mentioned previously it is requested that the therapist be given notice of such.
- Serenity Counseling has the right to contact law enforcement at any time there is a threat to any person on the property of Serenity Counseling including but not limited to the Therapist.
- Therapist reserves the right to protect themselves in accordance to Nebraska State law.

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STATEMENT OF CONFIDENTIALITY AND MANDATED REPORTING LAWS

All information pertaining to counseling is considered confidential. Confidentiality will be maintained per the means mandated by the American Psychological Association (APA) Code of Ethics 2014 and the Health Insurance Portability and Accountability Act of 1196 (HIPAA). However, at times, it is mandated by law that the therapist must disclose confidentiality. These situations are listed below. Clients will be notified prior to each report if possible, unless in doing so will cause more harm to the client's well-being.

- Duty to Warn: If the client is in immediate danger of inflicting harm to themselves (suicide) or others (homicide).
- If there is any type of child abuse suspected or reported in session including but not limited to sexual, physical, verbal, emotional abuse and neglect, as mandated by Nebraska statutes and reported according the Nebraska Health and Human Services standards.
- If a minor or vulnerable adult is the victim of a crime or is abused.
- If the client gives specific written permission, if the client is a minor (under the age of 19 years old) written permission must be given by the parent or legal guardian of the client. Disclosure of information is limited to that set forth by the client per signed waiver.
- If therapist is requested by a court of law. In such event, therapist will take any necessary procedures to assure that only requested information is disclosed. If client signs a release for attorney for any court action, however, please be aware that the other party will also have access to this information.
- It may be necessary to release information to insurance company, 3rd party payer or collection agency to collect payment.
- Youth in counseling are given the right of confidentiality in what they share in counseling. Information is not provided to parents unless it is deemed necessary for the safety and well-being of the minor. The minor will be informed that the information needs to be shared and given the option of sharing the information with or without the therapist present, or having the therapist share the information in their presence.
- Parents right to know: at times, it is required that information be shared with the parents of minors per state law on custody issues. Please provide a copy of any court documents that pertain to the custody or guardianship of the minor as well as any protection orders related to said minor.
- When an Authorization to Use, or Disclose Personal Health Information is signed only information requested per that signature will be disclosed. If further information or another agency is requesting information another document will need to be signed. If an outside agency is requesting information from Serenity Counseling Services, it will not be released until a signed release form is received in the office. A copy or faxed signature is acceptable.

- ONLY PERTINENT INFORMATION WILL BE RELEASED
- Please remember that when information is released either verbally or written from Serenity Counseling Services to another party the office and its therapist can no longer assure the confidentiality of how the information is used and handled.
- Confidentiality is important to all clients in this office. Therefore, it is required that you will keep information of whom you have seen in the counseling office confidential always. This also means not asking said individual(s) why they were there. If both parties agree mutual discussions about themselves are allowed. Any client violating the confidentiality of another client will be terminated from treatment in this office and referred to another counselor.
- **ALL MEDICAID CLIENTS**: By consenting to treatment with Serenity Counseling you are allowing this office to contact you identified primary care physician _____ by mail or phone to identify that you are in counseling with this therapist. This is due to the requirements of Heritage Health and is a benefit for you.
- **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:** You are aware of the Notice of Privacy Practice, which describes how medical information about me may be used and disclosed. You will be provided a copy of the Notice of Privacy Practice for your records at your request. _____(Initial)

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By signing this agreement, I am stating that I have read the above material and any questions have been answered to my satisfaction.

_____	_____
Client	Date
_____	_____
Parent/Guardian (if applicable)	Date
_____	_____
L Janeen Gill, MS LIMHP LMHP LPC PCDGC	Date

WHAT BROUGHT YOU TO COUNSELING?

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