



Phone: 843-673-0054 | Fax: 843-667-1549  
616 S Coit St, Florence, SC 29501

### PATIENT INFORMATION

CLIENT NAME: \_\_\_\_\_  
LAST FIRST MI PREFERRED  
CLIENT DATE OF BIRTH: \_\_\_\_\_ ☐ MALE ☐ FEMALE  
☐ CHILD\* ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED  
\*LEGAL PARENT/ GUARDIANS NAME: \_\_\_\_\_ \*SCHOOL: \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE  
EMAIL: \_\_\_\_\_ EMAIL REMINDERS\*? ☐ YES ☐ NO  
\*EMAIL REMINDERS ARE A COURTESY, AND NOT GUARANTEED  
HOME: \_\_\_\_\_ CELL: \_\_\_\_\_  
WORK: \_\_\_\_\_ PREFERRED: ☐ HOME ☐ CELL ☐ WORK  
REFERRAL? ☐ YES ☐ NO REFERRED BY: \_\_\_\_\_

### INSURANCE

PRIMARY INSURANCE PLAN NAME: \_\_\_\_\_  
GROUP NUMBER: \_\_\_\_\_ ID NUMBER: \_\_\_\_\_  
IS THE PRIMARY SUBSCRIBER THE SAME AS THE IDENTIFIED CLIENT? ☐ YES ☐ NO  
IF NO, FILL OUT THE INSURANCE INFORMATION BELOW  
SUBSCRIBER : \_\_\_\_\_ SUBSCRIBERS DOB: \_\_\_\_\_  
LAST FIRST MI  
SUBSCRIBERS ADDRESS: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE  
SUBSCRIBERS PHONE NUMBER: \_\_\_\_\_ SUBSCRIBERS EMPLOYER: \_\_\_\_\_  
PATIENTS RELATIONSHIP TO SUBSCRIBER: ☐ CHILD ☐ SPOUSE ☐ OTHER: \_\_\_\_\_

### PATIENT CONSENT - PAYMENT AUTHORIZATION - SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the staff at the next appointment without fail. I hereby authorize payment directly to The Counseling Center of Florence, LLC. If I have provided my insurance information in the box above, I hereby authorize The Counseling Center of Florence, LLC to bill my insurance for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ  
AND UNDERSTAND THE STATEMENTS MENTIONED ABOVE**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CLIENTS NAME \_\_\_\_\_ INSURANCE ID \_\_\_\_\_

**This page is completed for minors only**

**Our office requires a copy of any current custody, visitation, guardianship orders or active DSS kinship agreements to be on file prior to the client seeing the counselor.**

*Our office recognizes that often extended family members and friends help many of our families with minor children. A legal guardian is required to sign all forms for a minor client to enter counseling with our office. This information is provided to help us better protect your privacy. Please **ONLY** fill out the information below that pertains to your case:*

Biological Mother's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Biological Father's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Biological Parents Are: ☐ Married ☐ Separated ☐ Divorced ☐ Cohabiting ☐ Not married, living separately

If living separately, please tell us who child lives with the majority of the time: \_\_\_\_\_

If biological parent(s) are divorced and still have custody, please tell us if either parent has remarried and enter the stepparent's names below:

Stepmother's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Stepfather's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**\*Please ask the front office staff for an additional release form should you require one.\***

Has there been a termination of rights for either or both biological parent: ☐ YES ☐ NO

If yes, please enter parent name(s): \_\_\_\_\_

Was there an adoption for this client: ☐ YES ☐ NO If yes, please enter the date of adoption: \_\_\_\_\_

Adoptive Mother's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Adoptive Father's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Is this child currently in foster care: ☐ YES ☐ NO If yes, please complete the following:

Caseworker's Name \_\_\_\_\_ Agency \_\_\_\_\_ Phone Number \_\_\_\_\_

Foster Mother's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Foster Father's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Is there a current DSS kinship agreement in place? ☐ YES ☐ NO If yes, please complete the following:

Kinship Caregiver's Name(s) \_\_\_\_\_ Phone Number \_\_\_\_\_

Is there a current court order in place giving anyone **other than** the biological parents guardianship, custody or rights to client mental health information: ☐ YES ☐ NO

By signing this form, I am agreeing that all the information provided is correct to the best of my knowledge. I further understand that this sheet is only for informational purposes for this office. If I wish to sign a release for anyone listed on this form, I will complete a separate release of information form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Services Provided by

- **David Kahn, Ph. D., LPC, LPCS** (License #2173, #3847) is a Licensed Professional Counselor, Licensed Professional Counselor Supervisor, and is the Clinical Director of The Counseling Center of Florence, LLC
- **Erick Lownsberry, MA, LPC, LPCS** (License #7358, #9516) is a Licensed Professional Counselor and Licensed Professional Counselor Supervisor
- **Tai Yancey, MA, LPC** (License #8414) is a Licensed Professional Counselor
- **Clyde Talmadge Padgett Kahn, MA, LPC** (License #9152) is a Licensed Professional Counselor
- **Danielle L. Stanley, MA, LPC** (License #11082) is a Licensed Professional Counselor
- **Rebecca Causey, M.Ed., LPCA** (License #9131) is a Licensed Professional Counselor Associate and is supervised by Erick Lownsberry, MA, LPC, LPCS
- **Jessica B. Jordan, MA, LPCA, ATR-P** (License #10143) is a Licensed Professional Counselor Associate and is supervised by Erick Lownsberry, MA, LPC, LPCS
- **Sarah Moore, M.Ed., LPCA** (License #10437) is a Licensed Professional Counselor Associate and is supervised by Erick Lownsberry, MA, LPC, LPCS

**\*\*\*Full Professional Disclosure Statements for each counselor are available upon request.\*\*\***

### Other Rights

If you are unhappy with what is happening in therapy, we hope that you will speak with your counselor so a response can be given to your concerns. Such comments will be taken seriously and handled with care and respect. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your counselor's specific training and experience. Our office has interns from various colleges. You may be asked for interns to observe your session. You have the right to say "no". Please note that interns follow the same confidentiality regulations of our office.

### Appointment Reminders

In addition to appointment cards and the patient portal, email reminders can aid patients in remembering scheduled appointments. This is an automated system and can fail from time to time. You are still responsible for your appointment, even if you do not receive an email reminder. Please be advised, the email will be for informational purposes only. If you need to cancel your appointment, you will need to contact the office by phone. Our missed appointment/cancellation policy will still apply (see the missed appointment agreement page for additional details). If you would like to receive email reminders for your appointments, please ensure you have opted in on the front page. Please notify the administrative staff should you have any questions.

### Consistency in Treatment

During counseling, it is common to have a temporary increase in problem behaviors. Consistency is key to recovery. It is crucial that you be on time for your appointments and consistent with your scheduling in order for you to meet your treatment goals. If you fail to show for sessions, you may be asked to sign a consistency agreement. Your counselor will help you address the need for consistency as it pertains to your treatment. If you fail to comply with your consistency agreement, you may be referred back to your referral source to find alternative care. It is also important to follow the treatment recommendations of your counselor as to how often you should be seen. **We are not able to guarantee that certain days and times will be available.** Making counseling a priority and staying consistent will help you meet your therapeutic goals. Each insurance company and our office have policies on how many days can be between sessions, starting at 45 days and others as much as 90. Please check with the front office for your specific plan. **If there is a lapse in treatment exceeding these days, your counselor is required to terminate services.** You may be able return to counseling after a termination based on availability.

### Ethics

Counselors follow the Code of Ethics of the following organizations:

- The South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-educational Specialists. Website: <https://www.llr.sc.gov/POL/Counselors/>

## Emergency Protocol

You hereby authorize The Counseling Center of Florence, LLC to take any reasonable steps on your or your child's behalf in the event of an accident, injury, or illness during counseling sessions. This includes, but is not limited to, emergency first aid, nurse and/or ambulatory services. You agree to be liable for the cost of any such action taken on your behalf and hereby release The Counseling Center of Florence, LLC from liability thereof. You assume risk, by this consent, of any illness, accident, or injury to yourself while attending at The Counseling Center of Florence, LLC and release The Counseling Center of Florence, LLC from any liability thereof.

## Appointments

Appointments are usually scheduled for 53-60 minutes. The practice's hours are by appointment only. Clients are generally seen weekly or more/less frequently as schedule availability dictates. You may leave a voicemail 24 hours a day, 7 days a week, but calls are ONLY returned during regular office hours, Monday through Thursday. In the event of an emergency, you need to call or go to your primary care physician, your psychiatrist, or the local emergency room. Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. If an urgent issue arises, you should contact our office by phone. Your clinician or the Administrative Director will try to return your call within 24-hours, except on weekends and holidays. If you are unable to reach our office and feel you cannot wait for a return call, contact your primary care physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

## Record Keeping

A clinical chart is electronically maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

## Electronic Medical Records (EMR) System

The electronic medical records (EMR) system that we use is TherapyNotes®. TherapyNotes is a complete practice management system that is used to manage patient records, schedule appointments, meet with patients remotely, create documentation, and bill insurance. It is HIPAA protected and can be accessed through the following link: [therapyportal.com/p/counseling29501/](https://therapyportal.com/p/counseling29501/)

This system also offers an artificial intelligence (AI) component for creating notes that your provider may choose to use in creating notes that your provider may choose to use in creating patient documentation.

## Confidentiality

Each parent, whether the custodial or non-custodial parent of the child, has equal access and the same right to obtain all educational and medical records of the minor child (SC Law 20-7-100). Additionally, according to South Carolina Law, confidentiality may be breached in an attempt to collect unpaid fees for services rendered. In the event that there are unpaid fees, client's accounts are sent to a collection agency and a 30% service charge is added to the bill. A 10% late charge may be added to each month the payment is late, including late payments on previously arranged payment plans. Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." Information can only be shared with outside professionals after written consent is given by the patient. The information you share in counseling is protected health information (PHI) and is generally considered confidential by South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. However, there are limits to the privilege of confidentiality. These situations include:

1. When you sign a release for a person or office.
2. Suspected abuse or neglect of a child, elderly person, or a disabled person.
3. When it is believed you are in danger of harming yourself or another person or you are unable to care for yourself.
4. If you report that you intend to physically injure someone, the law requires this practice to inform that person as well as the legal authorities.
5. In an emergency, where your life or health is in immediate danger.

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6. If our office is ordered by a court to release information as part of a legal involvement. This includes a Guardian ad Litem (GAL) (A GAL routinely has a court order to access records.)
7. When you are being seen for court-ordered evaluations or treatment.
8. When your insurance company is involved, e.g., in filing a claim, insurance audits, case review or appeals, etc.
9. In natural disasters whereby protected records may become exposed.
10. Children under the age of 18 (We do maintain a reasonable right to privacy.).
11. Treating couples and families (We have a mixture of responsibilities to different family members.).
12. During a malpractice case or a disciplinary board hearing against a counselor.
13. If you use your mental condition as a defense in court.
14. In workman's comp cases.
15. As required by the Patriot Act.
16. As required by the Partner Notification Act.
17. When otherwise required by law.
18. Consultation, Supervision: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service. If you are working with a Licensed Professional Counselor Intern or Licensed Clinical Social Worker Intern, your clinical mental health counselor is required to discuss your case on a regularly scheduled basis with his/her supervisor. This will include your name, diagnosis, and content of therapy. The Supervisor is also required to maintain your confidentiality under the same legal guidelines as your clinical mental health counselor.

**IF THERE HAS BEEN A DIVORCE OR THERE IS A PERMANENT OR TEMPORARY COURT ORDER PERTAINING TO CUSTODY OR VISITATION, WE WILL NEED A COPY OF THAT ON FILE TO PROTECT THE RIGHTS OF ALL PARTIES INVOLVED.**

### **Outpatient Behavioral Health Consent for Treatment Form**

*The majority of this document is mandated by both South Carolina State Law and Public Law 104-191; it is provided for **your** protection. The Counseling Center of Florence, LLC has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them with The Counseling Center of Florence, LLC.*

#### **Contact Information**

The Counseling Center of Florence, LLC is located at 616 S. Coit St. in Florence, SC 29501. This is also our mailing address. Our usual office hours are Monday through Thursday 7:30 am to 7:30 pm. Our clients are seen by appointment only. Our telephone number is (843) 673-0054 (the voicemail is secure and confidential) and our fax number is (843) 667-1549.

#### **Counseling Services**

Counseling has both benefits and risks. Risks may include uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of counseling often requires discussing the unpleasant aspects of your life. However, counseling has been shown to have benefits for individuals who undertake it. Counseling often leads to a significant reduction in feelings of distress, increase satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss *outside* of sessions. The first 1-2 sessions will involve a diagnostic assessment for your needs. Based on the presenting symptoms, you may be diagnosed with a mental illness. Diagnoses are required for insurance and billing purposes, but it may follow you or affect your life. If you choose to not have an identified diagnosis, you may choose to self-pay. By the end of the assessment, your counselor will be able to offer you some initial impressions of what work might include. At that point, treatment goals will be discussed, and an initial treatment plan will be created. You should evaluate this information and make your own assessment about whether you feel comfortable working with your designated counselor. If you have questions about treatment, discuss them with your counselor whenever they arise. Please understand that in no way will there be any sexual relations between you and your counselor during or after treatment. Counselors are also not allowed to

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receive gifts of any kind. No blogs or public writings created by any counselor from this office represent any specific client.

***Counselors cannot have contact through any or all forms of social media including but not limited to Facebook, Facebook Messenger, Instagram, Twitter, or Yahoo Messenger. We currently do not permit contact through electronic means, such as email or text. Please understand that any relationship that you have with counselors and staff at The Counseling Center of Florence, LLC is considered a professional relationship. Therefore, any communication between you and any staff member may become part of your or your child's permanent file. This includes, but is not limited to, information pertaining to scheduling, insurance, billing, and clinical information.***

### **Consent for Counseling**

**By signing below, you are stating that you have read and understood this policy statement, and you have had your questions answered to your satisfaction.** You accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling. You understand that you may withdraw from counseling at any time and:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- We have no physicians on staff, and no one here can prescribe medications to anyone.
- Your counselor may need to consult with your physician, attorney, or other counselor.
- Your counselor is not available 24 hours a day.
- Appointments may be successfully canceled without fees as late as 24 hours prior to the scheduled time. (Our system counts down to the minute, in order to be fair to all clients. Ex. If you have an 8:00AM appointment, you would need to cancel prior to 7:59 the day before)
- Your counselor is licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, SC at (803) 896-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).
- The Administrative Director for The Counseling Center of Florence, LLC is Marlena Hanna-Lownsberry. She is a confidential administrator under state and federal law. She will be your major contact for problems, complaints, and commendations.

***I acknowledge that I have received and read The Counseling Center of Florence, LLC or Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment with my counselor.***

***I agree that I will be financially responsible for 100% of replacement or repair costs if myself or my minor child/family member damage or destroy any property of TCC or the counselor.***

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Date

### **INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES**

**Benefits and Risks of Telemental Health:** Telemental Health refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing. One of the benefits of Telemental Health is that the client and clinician can engage in services without being in the same physical location. Please note, counselors are subject to the requirements set forth by their licensure board as for where Telemental Health services may take place. Although there are benefits of Telemental Health, there are some differences between in-person psychotherapy and Telemental Health, as well as some risks. For example:

- Risks to confidentiality- Because Telemental Health sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. It is required for you to find a private location for your session where you will not be interrupted. You should protect the privacy of our session on your device.
- Issues related to technology- If you have difficulty maintaining a connection, or logging in to your session, you may be required to do in-person sessions in the future.

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**Electronic Communications:** Our office uses a HIPAA-compliant Telemental Health platform for video conferencing. There is no additional cost to you for using this service. You will need to have a secure device that has audio and video capabilities to use video conferencing. You will also need a reliable internet service. It is best if you are as close to your Wi-Fi router as possible to ensure a strong connection.

**Confidentiality:** Our office and staff have a legal and ethical responsibility to make the best efforts to protect all communications that are a part of your Telemental Health Services. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will utilize updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Telemental Health sessions and having passwords to protect the device you use for Telemental Health). The extent of confidentiality and the exceptions to confidentiality discussed in the consent for treatment form which you signed at the inception of your psychotherapy services still apply in Telemental Health. Please let our office know if you have any questions regarding these policies.

**Appropriateness of Telemental Health:** From time to time, we may request that you schedule an in-person session to “check-in”. Your clinician will let you know if they decide Telemental Health is not a good option for you. If this is the case, we would discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

**Emergencies and Technology:** Assessing and evaluating threats and other emergencies can be more difficult while engaging in Telemental Health services than in traditional in-person therapy. To address some of these difficulties, we are creating an emergency plan before engaging in Telemental Health services. You must identify an emergency contact person who is near your location who can be contacted in the event of a crisis or emergency to assist in addressing an emergent situation. By executing this document, you are authorizing your clinician to contact your emergency contact person as needed during such a crisis or emergency.

My emergency contact person is: \_\_\_\_\_

This person can be reached at: \_\_\_\_\_

If the session is interrupted for any reason **and you are having an emergency**, do not attempt to reconnect with your clinician. Instead, call 911 or go to your nearest emergency room. Call the office back after you have called or obtained emergency services. Another option in case of an emergency might be to call the National Suicide Prevention Hotline at 1-800-273-8255.

If the session is interrupted and you are not having an emergency, you may attempt to rejoin the session via the Telemental Health platform on which therapy was being conducted. If you are unable to rejoin the session within two (2) minutes, call our office at (843) 673-0054. We will attempt to help you reconnect with your clinician. TIP: If you are not plugged in, be sure your device is fully charged and/or close to somewhere you can plug in. If you are tethering to your phone/mobile hotspot for internet access, be sure that device is also fully charged and that you are ready to plug in if it starts to go dead.

As we are only ethically permitted to bill your insurance company for the time you are in session, you will be billed privately for any difference in the time you have scheduled and the time you were able to attend the session. This includes logging in late or leaving the session early for any reason, including technical difficulties or connection failure. This will be determined based upon your insurance provider’s policies.

**Records:** The Telemental Health sessions shall not be recorded in any way unless agreed to in writing with mutual consent. Records of your Telemental Health session are maintained in the same way records of in-person sessions are in accordance with office policies.

\_\_\_\_\_  
Client or Parent / Guardian Signature

\_\_\_\_\_  
Date

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### Telehealth Policies and Procedures

***The following policies and procedures must be followed in order to provide telehealth services for you or your minor child.***

If you are interested in telehealth, your counselor will determine if you are appropriate for this service, and we will make our best effort to inform you if your insurance will cover these services. Should your insurance provider change their policies regarding telehealth services, we will do our best to notify you of these changes, but it is ultimately your responsibility to understand your plan.. **TELEHEALTH SERVICES WILL NOT BE PROVIDED IN A MOVING VEHICLE OR OUT OF THE STATE OF SOUTH CAROLINA.** In order to complete telehealth services you must be located in South Carolina, in a confidential setting (ex. private office, your home, parked car alone, not in a store or public restroom). Your counselor will ask where you are located at the time of your session. **If you are unable to complete telehealth for any reason it is still a missed appointment and fees will apply.** Insurance companies require all telehealth sessions to have an uninterrupted connection with synchronous audio and visual in order for the service to be billed to and covered by your insurance provider. Cell phone notifications will disconnect a telehealth session.

Your Therapy Notes patient portal, which is required for telehealth services, must be set up at least 48 hours prior to the telehealth appointment. After your patient profile has been created, the office will send a link to the email address you provided so you may set up your portal account. This takes about 2 minutes and requires you to enter the patient name and create a password. Please keep your password in a safe place. The office does not know or see your password. If needed, the office is able to reset your password, but this must be done at least 15 minutes prior to your scheduled appointment. Please note, only one email address can be attached to the patient portal. If services are being provided to a minor child, please ensure they are aware of the email address you provided for the log in purposes. If the email address needs to be changed, a new password will need to be created and the previous email address will no longer have access to the portal. To return to the patient portal for future appointments, you can go directly to the following web page: [therapyportal.com/p/counseling29501/](https://therapyportal.com/p/counseling29501/) or visit our website at [counselingcenterofflorence.com](https://counselingcenterofflorence.com)

Clients are required to sign in on time for all telehealth sessions. Clients are also required to schedule their appointments for when they can be present the entire session. If you sign in late or leave the session early, you will be asked to pay the difference in what can ethically be billed to your insurance company and the time scheduled that we cannot bill. This will be based on each insurance company's policies. We cannot bill your insurance company for time that is scheduled that you were not present.

All copayments or fees are required to be paid at least 15 minutes prior to your session so the office can let your counselor know to begin the session. The office does not call you for payments. You must put a card on file that will be run the day of your appointment. A card on file will also be used for missed appointment fees.

Insurance companies require the client to be present for all telehealth sessions. This means *we cannot bill your insurance provider for telehealth sessions in which the identified client is not present.* Should you request this type of session, the payment would come directly from you.

\_\_\_\_\_  
Client or Parent / Guardian Signature

\_\_\_\_\_  
Date



CLIENTS NAME \_\_\_\_\_ INSURANCE ID \_\_\_\_\_

### **Fee Agreement and Financial Policy**

Thank you for choosing The Counseling Center of Florence, LLC. Please review this Fee Agreement and Financial Policy, which describes our fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancellations and missed appointments, payment methods, insurance reimbursement, and past-due accounts. If you have any questions, **please ask the front office staff prior to signing this Agreement and Policy.**

### **Service Rates with Corresponding Health Insurance Billing Codes**

This reflects the most common services provided by our staff and is not a comprehensive list. Additional codes may be used by your counselor as deemed appropriate.

- |         |   |               |       |
|---------|---|---------------|-------|
| • 90791 | Initial Intake  | 45-60 minutes | \$195 |
| • 90837 | Individual Therapy  | 53-60 minutes | \$155 |
| • 90834 | Brief Individual Therapy  | 38-45 minutes | \$140 |
| • 90832 | Brief Individual Therapy  | 25-30 minutes | \$85  |
| • 90847 | Family with Client  | 50 minutes    | \$155 |
| • 90846 | Family without Client   | 50 minutes    | \$155 |
| •       | Clients are responsible for the time that they schedule. If you are late or leave your session early you will be responsible for what insurance does not cover. |               |       |

\_\_\_\_\_  
Initial

### **Charges Not Covered by Insurance**

- Medical Records Requests  
*Our office follows the fee schedule set forth by South Carolina Legislature which states records are billed at \$0.65 per page for 1-30 pages, and \$0.50 per page for each additional page. There may be additional processing or shipping fees, if applicable. The maximum charge is \$150.00 per request for electronic records and \$200.00 per request for paper records.*
- Case Management \$40.00 per 15-minute increment (**unless specified below**)  
*Case Management includes indirect services provided outside your scheduled session time such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of a subpoena from the court; **the time is billed from port to port regardless of testimony given.***
  - o Letters \$100 for 1 page, \$50 for each additional page
  - o Court Time \$250 per hour
  - o Phone consultations \$40.00 per 15-minute increment

\_\_\_\_\_  
Initial

### **Additional Fees**

- Processing Fee for Credit Cards 3.5%
- **Late Cancellations/Missed Appointments \$50/\$100/\$155**  
*\*Fewer than 24 hours prior to appointment*
- Non-sufficient funds / Returned check \$45
- Past-due Accounts \$25 per month  
*\*Over 30 days*
- If account goes to collections, that companies fees will apply

\_\_\_\_\_  
Initial

### **Payment**

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the **Consent for Services**, which will be provided to you along with this Agreement and Policy and our **Notice of Privacy Practices**. Accepted methods of payment are cash, check, or credit cards (3.5% processing fee). Checks should be made payable to *The Counseling Center of Florence, LLC*. Please note, your HSA card may not be coded correctly to run on our machine.

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### **Insurance Reimbursement**

The Counseling Center of Florence, LLC accepts and processes insurance payments through a variety of insurance providers and Employee assistance plans. If you are using insurance or Employee assistance to pay for services, then we will:

1. Expect and accept payment of your copayment amount at the time of service;
2. File your claim with the primary insurance provider;
3. Receive payment from your insurance provider;
4. Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.

### **PLEASE NOTE**

**The Counseling Center of Florence, LLC files insurance as a courtesy to you, and you (not your insurance company) are ultimately responsible for your bill.** If your insurance company denies a claim filed on your behalf, then you are responsible for paying The Counseling Center of Florence, LLC the difference between the standard rate and the amount previously paid as co-payment.

I agree to: (1) allow The Counseling Center of Florence, LLC to bill my insurance directly for services provided under Consent for Services; (2) give The Counseling Center of Florence, LLC permission to release any information the insurance company may require in order to process payment; appoint The Counseling Center of Florence, LLC as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to The Counseling Center of Florence, LLC; and (4) agree to assist with the claims process as required by The Counseling Center of Florence, LLC or my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in counseling are reimbursed by insurance companies.

Self-Pay clients agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

\_\_\_\_\_  
Client or Parent / Guardian Signature

\_\_\_\_\_  
Date

### **Missed Appointment Agreement**

Our office wants to work with you and your family to meet your treatment goals and gain the most out of your therapy sessions. Your time is important, and your appointment time is for you only. Our office does not double-book clients. If you miss your appointment, there is an automatic consequence for the counselor as they do not get paid for their time. There are fees when you miss an appointment.

Missed appointment fees are \$50.00 for the 1st missed appointment. The 2nd missed appointment fee is \$100.00. The 3<sup>rd</sup> missed appointment fee is \$155.00 and will remain at the \$155.00 fee for any other missed appointments. Our office **CANNOT** bill your insurance company for a missed appointment. You are responsible for missed appointment fees and **CANNOT** be rescheduled until the missed appointment fees are paid. *Medicaid clients can not be charged for missed appointments. Medicaid clients may be referred back to their referral source after missing two appointments. Insurance carriers will not pay for late cancellations or missed appointments.*

**IF YOU MISS AN APPOINTMENT AND FAIL TO CONTACT THE OFFICE, OUR SYSTEM REMOVES ANY FUTURE SCHEDULED APPOINTMENTS. IT WILL ALSO REMOVE ANY APPOINTMENTS FROM ACCOUNTS WHICH YOU ARE THE GUARANTOR ON.**

The following are ways to avoid missed appointment fees:

- 1) Be on time and at each scheduled appointment.
- 2) Schedule appointments that you know will work for you and your family.
- 3) Give 24 hours' notice if you will have to miss an appointment. Our system counts down to the very minute.

***Providing 23 hours and 59 minutes is still a missed appointment. You may call our office 24 hours a day, 7 days a week, and leave a message on our secure and confidential voicemail system if it is outside of normal business hours.***

\_\_\_\_\_  
Client or Parent / Guardian Signature

\_\_\_\_\_  
Date

CLIENTS NAME \_\_\_\_\_ INSURANCE ID \_\_\_\_\_

**By signing this line, I agree that I have read this document in its entirety and agree to abide by the policies and procedures.**

\_\_\_\_\_  
Client or Parent / Guardian Signature

\_\_\_\_\_  
Date

**Card Holder Authorization:**

Upon scheduling your first appointment, you have the *option* to provide credit card information, which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, returned checks, balances due from sessions, or past due account balances. ***A signed cardholder authorization is required to run a card via telephone or without the card present.*** A receipt can be uploaded to your Therapy Notes portal at your request.

*Clients participating in telehealth sessions **must** have a card on file 48 hours prior to the telehealth session in order for the session to be completed.*

**Type of card (circle one):**

Visa

Mastercard

American Express

Discover

Card#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration: \_\_\_\_\_ / \_\_\_\_\_

Security Code: \_\_\_\_\_

Billing Address for Card:

\_\_\_\_\_  
Address City State Zip Code

Name on Card: \_\_\_\_\_

**I authorize The Counseling Center of Florence, LLC to charge this credit card as needed according to the terms specified in this Agreement and Policy.**

Signature of Card Holder: \_\_\_\_\_ Date: \_\_\_\_\_