Aspen

Counseling Services, PLLC

**Adult Intake Form (Personal Data)**

**What is the main concern that led you to consult me****? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did it begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatric History/Outpatient Treatment**

**Have you ever had outpatient treatment for a psychiatric disorder****?** (Circle one) Yes No

 **If Yes, what was the disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **When & where did you receive treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **What was the name of your therapist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you authorize me to communicate with your therapist?** (Circle one) Yes No (If Yes, please fill out the “Authorization to Release/Request Information sheet)

**Hospitalizations**

**Have you ever been hospitalized for a psychiatric disorder?** (Circle one) Yes No

 **If Yes, what was the disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Which hospital & what were the dates of the hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to Aspen Counseling Services, PLLC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name (First, MI, Last):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** (Circle one) Male Female **SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*May we send a text message with an appointment reminder? (Circle one) Yes No

\*May we leave a message? (Circle one) Yes No

**Marital Status:** (Circle one) Single Married Separated Divorced Widowed Other

**Employment Status:** (Circle one) Employed Student Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

**What illness or surgeries have you had in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any illness at present?** (Circle one) Yes No

 **If Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had a head injury?** (Circle one) Yes No

 **If Yes, when & how did it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had an EEC or a CT Scan of your head?** (Circle one) Yes No

 **If Yes, when & what are the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of your Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you authorize me to communicate with your physician?** (Circle one) Yes No (If Yes, please fill out the “Authorization to Release/Request Information sheet)

**Medication History**

**What medications are you taking now (medical or psychiatric)?** (Or a copy of list)

***Medication Name Total Dosage When do you take them? Prescribing Physician***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use non-prescription medications?** (Circle one) Yes No

 **If Yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you or have you used recreational or illegal drugs?** (Circle one) Yes No

 **If Yes, which drugs & how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you drink alcohol?** (Circle one) Yes No

 **If Yes, are you concerned about how much you drink?** (Circle one) Yes No

**Do you smoke or vape?** (Circle one) Yes No

 **If Yes, what & how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Beverages with Caffeine:**

Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_ Tea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cups per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Soda/Pop \_\_\_\_\_\_\_\_\_\_\_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cups per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Aspen

 Counseling Services, PLLC

**Payment Contract Services**

Name(s) of Client(s) receiving services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for payment (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Federal Truth in Lending Disclosure Statement

**Clients with Insurance Coverage:**

Some Insurance companies have incorporated your Social Security Number as part of your ID number. Please check your insurance card to see if this is required and fill in your full ID number below. Please provide your insurance card to the receptionist so we can get a copy of it to file your claims.

|  |  |
| --- | --- |
| Insurance Carrier |  |
| Full ID/Policy Number |  |
| Group Number |  |

Deductible amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Payment/Co-Insurance Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ %

We suggest you confirm your benefits and eligibility with your insurance company. Your insurance company may not pay for services that they consider to be not effective, not medically or therapeutically necessary, or ineligible. You are responsible for any amount not covered by insurance. It is your responsibility to know if the desired therapist is accepted by your insurance company.

**Clients Without Insurance Coverage:**

I (we) agree to pay Aspen Counseling Services, PLLC. a rate of $150.00 for the first session and $125.00 per follow-up session to be paid at the time of service, defined as a 45-60 minutes depending on services rendered.

**All Clients: Please read and sign below:**

Payments & Co-payments are due at the time of service. Any amount due on the clients account will be issued a statement showing the balance. Statement charges are due within 30 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement.

I authorize Aspen Counseling Services, PLLC to disclose case records (diagnosis, case notes, psychological reports, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Aspen Counseling Services, PLLC. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and this consent expires when the insurance coverage expires.

By signing below, I agree that I have received, read and agree to the terms and conditions of this form including the Federal Truth in Lending Disclosure Statement for Professional Services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of person responsible for payment Date

 *Aspen Counseling Services, PLLC*

**Payment Policy**

Thank you for choosing Aspen Counseling Services, PLLC as your mental health provider. We are committed to providing you with quality care. Because some of our patients have had questions regarding patient & insurance responsibility for services rendered, we have developed this new payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

*Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amounts, co-insurance and/or and other balances not paid by your insurance company. Your signature on this document indicates that you agree to pay for any outstanding charges that incurred in this office in a timely manner (within 30 days)*

**Insurance:** We participate in several insurance plans. If you are not insured by a plan we are in network or have contracts with, payment in full is required at the beginning of each session. If you are insured by a plan we are in network or have a contract with, but don’t have an up-to-date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits are **your** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Co-payments & deductibles:** All copayments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments & deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.

**Proof of Insurance:** All patients must complete our patient information forms before seeing the therapist. We must obtain a copy of your driver’s license, and current insurance card for proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full balance of the claim.

**Claim Submission:** We will submit your claims & assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

**Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make sure the appropriate changes are made to maximum your benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

**Non-payments:** If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by that you have 30 days to find alternative medical care. During that 30-day period, our therapist will only be able to treat you on an emergency basis and you will have to pay for the session in full prior to the appointment. **15 minutes Late or No-Show Appointment Fee:** Our policy is to charge $50.00 for a late/missed appointment not cancelled within 24-hour notice. These charges are your responsibility and cannot be billed to insurance.

*\*\*Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual & customary charges in your area. Thank you for your understanding of our payment policy. Please let us know if you have any questions or concerns.* ***I have read & understand the payment policy. I agree to abide by its guidelines.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of person responsible for payment Date

Aspen

Counseling Services, PLLC

1019 6th Ave SE, Watertown, SD 57201

Phone: (605) 878-0606 Fax: (605) 878-0214

 **Authorization to Release/Request Information**

***Patient’s Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Date of Birth:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize Aspen Counseling Services, PLLC to release and/or request my health information to the person or organization designated below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax; (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax; (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax; (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to cancel this authorization by sending a written notification to Aspen Counseling Services, PLLC. However, I understand my cancellation will not be effective to the extent that Aspen Counseling Services PLLC has already taken action regarding the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the recipient of this information may re-disclose it and that the information will no longer be protected by the HIPPA Privacy Rule. I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Signature** (or parent/guardian if minor) Date

*Aspen Counseling Services, PLLC*

1019 6th Ave SE Watertown, SD 57201

Phone: (605) 878-0606 Fax: (605) 878-0214

**Consent for Treatment and Agreement to Terms**

**Consent for Treatment:** By signing below, you are giving informed consent for treatment. By signing below, you are also stating that you have received, read and understood the *Client Information and Office Policy Statement* and agree to its terms, unless otherwise stated in writing. I give my consent for treatment with Aspen Counseling Services, PLLC and its associated professional staff to include evaluations, psychotherapy, and involvement in the treatment planning process. I understand that the client may decline at any time specific treatment recommendations.

**Billing and Cancellations**: I understand that Aspen Counseling Services, PLLC will release copies of my medical records and information as to the nature of my treatment as requested by the insurance company. I understand that I will be charged a late cancellations or failed appointment (less than 24-hours’ notice). There will be a charge of $50.00, which is not covered by insurance and will need to be paid before next appointment. You may leave a message or cancel 24-hours a day.

**HIPPA & Notice of Privacy Practice & Limits of Confidentiality Statements**: By signing below, you are stating that you have received, read & understood the ***HIPPA, Limits of Confidentiality*** and agree to it terms, unless otherwise stated in writing.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Aspen Counseling Services PLLC’s ***Notice of Privacy Practice***. I understood that I can contact Aspen Counseling Services, PLLC if I have any questions regarding the Notice of my privacy rights.

**Letters:** If a disability letter, companion pet letter, or letters regarding your ability to work is required attesting your needs, the therapist will provide it for a fee of $35 per one-page letter and $25 for each additional page. Letters are only provided to clients who have been seen for 6 sessions or longer.

**Court Appearance:** Clients are discouraged from having their therapist subpoenaed. Though the client’s attorney, who initiates the subpoena request is responsible for the court appearance and testimony fees, it does not mean that the therapist's testimony will be solely in in the client's favor. Your therapist will only testify their professional opinion and to the facts of the case.

The following fees apply for court appearances:

Preparation time (including submission of records) $220/hour

Phone calls $220/hour

Depositions $250/hour

Email or written letters $200/hour

Time required in giving testimony $250/hour

Mileage $0.54/mile

Time away from office due to depositions or testimony $220/hour

Filing a document with the court $100 (Plus court fees)

The minimum charge for a court appearance $1500

\*Any and all legal fees and costs incurred by the therapist as a result of the legal action.

**PLEASE NOTE:** A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 “express” charge. If the case is reset with notice of less than 72 business-hours, the client will be charged $500 (in addition to the retainer of $1500). All fees are doubled if the therapist has to postpone or interrupt plans to go out of town.

\*Fees are subject to change without notice please call for the latest fee schedule. Insurance companies are subject to change. Please call to verify that your insurance is accepted.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Signature** (or parent/guardian if minor) Printed Name Date