CLIENT CONSENT TO TREAT

Client Information

First Name:	Middle Name:	Last Name:
Full Address:		
DOB:	Age:	SS#:
Home Telephone #:		Can we leave a message at home? ☐ Yes / ☐ No
Work Telephone #: ext #:		Can we leave a message at work? ☐ Yes / ☐ No
Cell Telephone #:		Can we leave a message on your cell? ☐ Yes / ☐ No
Please Indicate by # the order in which you wish to be contacted: _____ Home / _____ Work / _____ Cell		
Email Address:		
Marital Status:		Spouse's Name:
Occupation:		☐ Full-time ☐ Part-time
Employer:		
Student: ☐ Full-time ☐ Part-time		School:
How did you hear about LifeWorks?		

If A Minor (Must Sign Custody Addendum)

Parent / Guardian Name:	
Address:	
Home Telephone #:	Work Telephone #: ext #:

Responsible for Payment

Name / Agency:	
Address:	
Telephone #:	Agency Contact Person*:
*LifeWorks reserves the right to contact this person/agency to verify their agreement to be financially responsible.	

For Office Use Only:

PLEASE CONTINUE ON THE NEXT PAGE ➔

INITIAL EACH ☐ AFTER TOPIC REVIEWED:

CONFIDENTIALITY:

☐ LifeWorks Counseling & Consulting Inc. will maintain the practice of holding all communication between the therapist/mediator and the client in strictest confidence and will not allow information to be released to anyone without written permission or according to law. Your mental health record will be handled according to the following legal requirements: 1) Therapists are required to report circumstances wherein a client states an intention to harm self or others, in cases of recent or ongoing abuse, and with court related custodial concerns; 2) Indiana law requires reporting any activity wherein a child or adolescent describes participating in circumstances involving sexually oriented activities. It is LifeWorks Counseling & Consulting Inc's. legal responsibility as a care provider to report such to the respective division of Family and Children's Services (welfare) and respective police department. Thus, such information cannot be considered confidential information within the counseling setting, and so it also cannot be maintained only between the client and therapist/care provider; 3) Court ordering of unlicensed therapists to do so; 4) Notice of Privacy Practices.

CANCELLATIONS:

☐ Making an appointment is a contract between the therapist/mediator and the client that both will be present at the appointed hour. However, we are aware that genuine emergencies do arise which preclude the keeping of the appointment. Late cancellations, however, do not allow us to fill the hour with persons who are waiting for an appointment. **Cancellations require 24 hour notice. There is a minimum $35.00 fee for late cancellations or missed appointments*.**

☐ *Note: **Missed appointments without cancellation notice will be expected to be paid at the full-fee rate and cannot be billed to insurance**. Even if your therapist uses the reminder call system, you are still responsible for payment of missed appointments whether or not a reminder call was placed. LifeWorks reserves the right to exercise the option of discontinuing treatment after the second occurrence and assessing a full-fee charge against missed appointments.

FEES:

☐ Checks are to be made payable to **LifeWorks Counseling & Consulting or LifeWorks.**

☐ I understand and agree that I am personally and fully responsible to pay for all services rendered. I am to pay in full at the time of appointment and I am responsible to file any claim for reimbursement with my insurance carrier, unless LifeWorks is contracted to do so (the therapist will provide reasonable information [i.e. Diagnosis Code] needed to process such claims). If I am covered by Medicaid or have insurance with a carrier which has a contract with LifeWorks, LifeWorks will file claims on my behalf. I agree to pay any deductible or copayments required by my insurance company. I also agree to pay for any services not covered by my insurance carrier's contract with LifeWorks. If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, LifeWorks shall be entitled to reasonable attorney's fees and related Court costs and expenses, in addition to any other relief to which it may be entitled.

NON-COVERED SERVICES:

☐ A Non-Covered Service is a service utilized for the benefit of counseling and is not covered by an individual insurance benefit plan. Some of those services include but are not limited to: A service provided that is rejected by the insurance entity, psychological testing and interpretation, services provided regarding legal matters such as court preparation and appearances, depositions, expert and non-expert witness services, extended counseling sessions beyond the billable clinical hour, phone calls in excess of ten minutes, etc. Payment for a Non-Covered Service is the responsibility of the client or parent/legal guardian. A lapse in mental health coverage is also considered a Non-Covered Service and is the responsibility of the client or parent/legal guardian.

Last Name	First	Middle	Date	Client #

INITIAL EACH ☐ AFTER TOPIC REVIEWED:

☐ When possible, a LifeWorks clinician or the Office Manager will discuss the estimated fee associated with a Non-Covered Service. Fees are due at the time service is rendered. Services provided regarding legal matters such as custody, court preparation, court appearances, depositions (as an expert or non-expert witness) and travel time will be estimated by the clinician at which time 50% of the estimated fee is due one (1) week prior to this service being provided.

SECURITY:

☐ LifeWorks holds the right to secure it's premises with installed security cameras and software. It will be used for the expressed purpose of securing safety for our clients and team.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT – HIPAA:

☐ I have received, reviewed and accept this policy as reflecting the new Health Information Portability and Accountability Act (HIPAA). LifeWorks Counseling & Consulting, Inc. will maintain this acknowledgement in my mental health record.

OTHER:

☐ A one week notice is required to release copies of any record for medical, billing or legal purposes (see Notice of Privacy & Practices). LifeWorks reserves the right to bill for these services, as is customary with Indiana law.

☐ I understand that I am responsible for reviewing and understanding my benefit coverage for mental health services. I understand that LifeWorks will verify these benefits with my insurance company. I will not hold LifeWorks responsible for any discrepancy and am responsible for any fees not covered by my benefits.

☐ I have received the LifeWorks Intake Letter.

☐ LifeWorks has pets who are on the premises at specific times. I understand the pets are used for therapeutic purposes. I will not hold LifeWorks or any person associated with LifeWorks responsible for any transferable disease or accident that may occur.

☐ LifeWorks utilizes the area outside the building as an extension of counseling when appropriate. I consent permission.

☐ I HAVE READ, UNDERSTAND THE ABOVE POLICIES & PROCEDURES, AND **CONSENT TO TREATMENT**.

Signature (Client/Parent/Guardian)	Date
Witness	Date

UPDATED 10.1.18

Last Name	First	Middle	Date	Client #