magnolia counseling

Hello, welcome to Magnolia Counseling. I hope that our work together will be beneficial to you as well as an educational experience, which you may use from this time forward. I am currently a Licensed Marriage Family Therapist working for a non-profit organization. This means that Magnolia Counseling renders all services and all payments shall be made in care of **Magnolia Counseling**. Below is a set of agreements that all our clients sign upon treatment by the above, at this setting.

GENERAL CONSENT

The undersigned and/or responsible relative or person hereby consent to, authorize and request the above counselor(s) and personnel to administer and perform any and all treatments, therapy and counseling which may now or during the course of the clients care be deemed advisable or necessary, including follow-up procedures. The undersigned hereby gives consent to be charged for above stated services in accordance with established agreed upon fee between client and counselor.

FINANCIAL POLICY

The staffs at *MAGNOLIA COUNSELING* (hereafter referred to as the clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy, which provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form, *Payment Contract for Services*, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amount covered, and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied no emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or the following charge cards: **VISA OR MASTERCARD**.
Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

The Office Manager can answer questions regarding the financial policies.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ **Date:** ___/___/_____

Co-responsible party: _____ **Date:** ___/___/_____

magnolia counseling

PAYMENT CONTRACT

Name(s):_____

Address: _____City: _____State: _____Zip: _____

Bill to: Person responsible for payment of account: _____

Address: _____ City: _____State: _____Zip: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay *MAGNOLIA COUNSELING*, (hereafter referred to as the clinic), a rate of $ _____ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).

Or

I (we) agree to pay MAGNOLIA *COUNSELING*, (hereafter referred to as the clinic), a ***sliding scale rate*** of $ _____per month / Session (defined as 45–50 minutes weekly for assessment, testing, and individual, family and relationship counseling).

A fee of $ _____ is charged for group counseling. The fee for testing includes scoring and report-writing time.
The full fee is charged for missed appointments or cancellations with less that 24 hours' notice.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

Name of Third Party Payer: _____

1) $ _____ Deductible amount (paid by insured party)
2) Co-payment $_____ ($ _____ /clinical unit) for first _____ visits.
3) Co-insurance_____ % ($ _____ /clinical unit) up to _____ visits.
4) The policy limit is _____ per year: ___annual ___ calendar
5) Has deductible been met? □ yes □ no Amount $_____

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ____/____/_____

Release of Information Authorization to Third Party

I (we) authorize Magnolia Counseling to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Magnolia Counseling .

I (we) 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 (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ____/____/_____
Person(s) receiving services: _____ Date: ____/____/_____
Person(s) or guardian(s): _____ Date: ____/____/_____

CONFIDENTIALITY

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic. Insurance companies and other third-party payers are given information that they request regarding services to clients. Information, which may be requested, includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you

at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

_____ HOME Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? ____ Yes ____ No

_____ WORK Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? ____ Yes ____ No

_____ OTHER Phone number: _____
How should we identify ourselves? _____
May we say the clinic name? _____Yes _____ No

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client's name (please print): _____

Client's (or guardian's) signature: _____ **Date:** ____/____/_____

Client's name (please print): _____

Client's (or guardian's) signature: _____ **Date:** ____/____/_____

CREDITCARD PAYMENT AGREEMENT: 3% Charge per transaction

I authorize *MAGNOLIA COUNSELING* to keep my signature on file and to charge my _____ (type of charge card) account for:

__ All balances not paid by insurance or other third-party payers after 60 days. This total amount cannot exceed $____ .

__ Recurring charges (ongoing treatment) as per amounts stated in the signed Payment Contract for Services with this clinic.

I assign my insurance benefits to the provider listed above. I understand that this form is valid throughout the duration of treatment unless I cancel the authorization through written notice to this clinic.

Client's name: _____CVS Code: _____

Cardholder's name: _____

Cardholder's billing address: _____

City: _____ State: _____ Zip: _____

Charge card number _____ Expiration date: _____

Cardholder's signature: _____ **Date:** ____/____/_____

magnolia counseling

RULES FOR CLIENT CONDUCT

1. No drugs/alcohol are allowed on MAGNOLIA COUNSELING, premises or in adjacent parking areas.
2. No illicit drugs transactions are allowed on MAGNOLIA COUNSELING premises, in adjacent parking areas or with other MAGNOLIA COUNSELING clients.
3. Clients are expected to refrain from using drugs with other MAGNOLIA COUNSELING clients and engaging in sexual behavior on MAGNOLIA COUNSELING premises or with other clinic clients.
4. Violence (expressed or implied, toward fellow patients, staff, or agent of the Corporation operating on MAGNOLIA COUNSELING's behalf) is strictly prohibited. Violation of this rule may result in prosecution to the full extent of the law.
5. No weapons are allowed on MAGNOLIA COUNSELING premises.
6. Stealing is prohibited. Violators will be prosecuted. Stolen property is not allowed on the premises and may be confiscated for law enforcement officials.
7. Any client who destroys or vandalizes MAGNOLIA COUNSELING property will be held responsible.
8. Clients are expected to respect staff authority and instructions at all times.
9. Clients are not permitted to wear drug or alcohol promotional material and sexually explicit attire on MAGNOLIA COUNSELING premises.
10. Clients are expected to respect the effort of other clients to achieve or maintain a "Dysfunction" free life style.
11. Clients and family members are not permitted on MAGNOLIA COUNSELING premises or at MAGNOLIA COUNSELING functions while under the influence of drugs or alcohol.
12. Clients are prohibited from entering empty offices, using phones or office equipment without permission.
13. Clients are expected to clean up after themselves (i.e. pick up trash, return chairs and generally return the area to its optimum condition.
14. Clients are expected to pay all fees promptly. Clients who have become delinquent, or who refuse to pay their portion of their Sliding Scale Fee may be terminated from treatment.
15. Clients are required to participate in their Treatment Plan.

FAILURE TO COMPLY WITH THESE RULES MAY RESULT IN: a) Suspension or discharge From treatment or b) other consequences deemed appropriate by the Treatment Team.

ARBITRATION CLAUSE

I also understand that my counselor/therapist is a __Marriage Family Therapist_____ and is supervised by _____. In case of any disagreement between the patient or dependent (if a minor) or The heirs-at-law or personal representative of a patient, as the case may be, and the provider including the agency or its agents, involving any claim in tort or contractual, the same shall be submitted to arbitration. Within fifteen (15) days after the Patient or Provider shall give notice of such appointment to the other. Within a reasonable amount of time after such notices have been give, the two arbiters, so selected shall select a neutral arbiter and give notice of the selection thereto to the parties. The arbiters shall hold a hearing within a reasonable time from the date of notice of selection of neutral arbiter. All notices or other papers required to be served, shall be served by United States mail. Except as provided herein, the arbitration shall be conducted in accordance with and governed by the provisions of Title 9 of the California Code of Civil Procedure. The CLIENT may withdraw from the arbitration portion of this agreement within thirty (30) days from the date of this agreement by notification of his/her intent to do so to the provider by registered mail.

NOTICE: By signing this agreement you are agreeing to have any issue of malpractice decided by neutral Arbitration and you are giving up your right to a jury or court trial.

By my / our signature(s), I / we consent to this agreement and each acknowledge receipt of a true copy of this agreement.

Client's name (please print): _____

Client's (or guardian's) signature: _____ **Date:** ___/___/_____

Client's name (please print): _____

Client's (or guardian's) signature: _____ **Date:** ___/___/_____