Southside Counseling Center, LLC
PO Box 2387, 6072 Godwin Blvd.
Suffolk, VA 23432
757-255-2555 757-255-7009 (fax)

Director:
Sharon W. Krumpe, PhD, LPC, LMFT

Associates:
Krista Everett, MSW, LCSW
Char Bentley, LCSW, BCD
Carey Slone, LCSW

Welcome to Southside Counseling Center. We are happy to have you as a client and will strive to provide you with the highest possible quality of service. If you like, you can download the necessary forms from the "New Client Packet" section of the Forms page. It will save time if you can fill out the forms before your first appointment and then bring them with you. Our entry door is on the **front** of the building (6072), and there is parking at the rear of the building.

Before you come for your first visit, we want to inform you about our policies:

- We do not have anyone who can watch your underage children while you are in session. Children under the age of 12 must be supervised by an adult, both inside and outside the building. In addition, children under the age of 8 must be supervised by an adult while in the restroom.
- When minor children participate in counseling, all adults holding **legal** custody must sign the Registration, Informed Consent and Consent to Treat Minors forms, thus agreeing to the children's participation. <u>Until this requirement is met, a minor cannot be seen at our practice.</u>
- Please give us at least 24 hours' notice if you must cancel a scheduled session; we reserve the right to charge you $50 for each no-show or late cancellation.
- We cannot accept credit cards at this time; payment **in cash or by check** is due (either the insurance co-pay or full fee) at each session.
- Your 1st visit will probably be scheduled for 45 minutes only. Please arrive early if you need to fill out paperwork. Arriving late will shorten the time your therapist can spend with you.

We're looking forward to meeting and working with you. Please do not hesitate to call if you have questions before your appointment. You can access our website at www.southsidecounseling.net, and you can email us at info@southsidecounseling.net. Client satisfaction is our goal; if, at the end of your first, or any other session, you believe that you and your therapist are not a good "fit," please let the front office know. We can, in most cases, move you to another clinician, and we will be happy to do so.

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Phone: 757-255-2555 Fax: 757-255-7009

Client Registration

Name ____ Birthdate _____________ Sex: M F
Address ________________________________ City _____________ State ___ Zip _________
Phone (H) __________________ (W) ________________ SS# _________________________
Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Student ___
Employer __________________________________ Full-time ___ Part-time ___ Retired ___ Self ___
Work Address ______________________________ City __________ State ___ Zip ________
Cell Phone ___________________Pager ______________ Email ________________________
Spouse's Name _______________________________________ Birthdate _________________
Address ________________________________ City _____________ State ___ Zip _________
Phone (H) __________________ (W) ________________ SS# _________________________
Emergency Contact _______________________________________ Phone ________________
PRIMARY PHYSICIAN_________________________ **Phone Number**________________

Person Responsible for Payment (Must live locally)

Name __________________________________ Birthdate _____________ Sex: M ___ F ___
Address ________________________________ City _____________ State ___ Zip _________
Phone (H) __________________ (W) ________________ SS# _________________________
Relationship to Client ________________________ Driver's Lic/State _________________
Employer __________________________________ Full-time ___ Part-time ___ Retired ___ Self ___
Work Address ______________________________ City __________ State ___ Zip ________
Cell Phone _____________________ Pager ______________ Email _____________________

Primary Insurance Company

Insurance Company _____________________________________ Phone _________________
Policy Number ____________________________ Group Number _______________________
Policyholder's Name _____________________________ Self ___ Spouse ___ Parent ___ Other ____
Birthdate _________________ Sex: M ___ F ___ Employer/Group Name _____________________
Address ________________________________ City _____________ State ___ Zip _________
Phone (H) __________________ (W) ________________ SS# _________________________

Secondary Insurance Company

Insurance Company _____________________________________ Phone _________________
Policy Number ____________________________ Group Number _______________________
Policyholder's Name _____________________________ Self ___ Spouse ___ Parent ___ Other ____
Birthdate _________________ Sex: M ___ F ___ Employer/Group Name _____________________
Address ________________________________ City _____________ State ___ Zip _________
Phone (H) __________________ (W) ________________ SS# _________________________

Authorization to Release Information and Assign Benefits

I authorize the release of any medical or other information to the above named insurance company(s) and/or their designated agent(s) necessary to approve and/or pay this claim. I hereby assign and authorize payment of all medical benefits payable pursuant to this claim to Southside Counseling Center, LLC, for services rendered; I also agree to pay any applicable co-payments and outstanding account balances. **If my therapist accompanies me to or testifies on my behalf in any court proceeding, I agree to pay said therapist the hourly fee of $250 for all time spent, including preparatory and travel time. I understand that SCC has the right to charge, and I agree to pay, $50.00 for each no-show and late cancellation.**

Client/Parent Signature _____________________________________ Date ________________

Client/Parent Signature_____________________________________ Date ________________

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APPOINTMENT CANCELLATION/LATE POLICY

Our goal at Southside Counseling Center is to provide outstanding care to all our clients. Appointments missed without notification and last minute cancellations affect the schedule of the clinicians and take away appointments from clients who have a desire or an emergency need to be seen. Although the following policy will not apply to the majority of clients, it will hopefully emphasize the importance of keeping scheduled appointments.

A fee of **$50.00** may be charged for failure to show for an appointment OR for late cancellations (within 24 hours). *This fee will not be submitted to your insurance; it will be collected directly from you.* Our contract with some Employee Assistance Programs prohibits our charging clients such a fee; in those cases, we are generally allowed by the EAP to count the "no-show" or late cancellation as one of the allowed sessions.

If you need to cancel an appointment, we ask that you do so 24 hours in advance, so that we can utilize that appointment time for some other client who wishes to use it. If you realize you will not be able to attend a previously-scheduled appointment, please call and either speak to someone directly or leave a message on our practice voice mail. As a courtesy only, we do make reminder calls for appointments. *If you do not receive your message, or if we have incorrect contact information, this policy will still apply.*

By signing below, you acknowledge that you have been advised of and agree to the above policy.

I/We,____________________________________ am/are fully aware of the "Appointment Cancellation/Late Policy" outlined above.

Client/Parent signatures ______________________   ________________________

Date __________________________

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Informed Consent and Privacy Practices Notification

Maintaining confidentiality generally means that anything that occurs in psychotherapy is not divulged by the therapist. This is mostly true, although there are some situations that make exceptions to this rule. **Privilege** refers to the client's ability to protect information in a legal proceeding. With these definitions in mind, I acknowledge and consent to the following:

Exceptions to Confidentiality and/or Privilege

Mandated reporting by therapist

1. If a therapist suspects that a client is a danger to him/herself physically or incompetent mentally
2. If a therapist suspects that a client intends to bring physical harm to others
3. If a client has physically, sexually, or (severely) emotionally harmed or neglected a minor or a dependent adult

Situations in which privilege does not apply or is limited

4. If a client brings a lawsuit against the therapist
5. If another person is in the room
6. If a court requires the client or therapist to testify
7. If the client is being evaluated for a third party
8. If a client, or member of a client's family, commits a crime on the premises or against any therapist for, or employee of, Southside Counseling Center, LLC

Items 1, 2, and 3 above are extreme situations that are exceptions to confidentiality and in which the therapist MUST file a report with the appropriate agency. All other reasonable means would be exhausted prior to using this option; even then, the client's cooperation would be encouraged.

Disclosure of Information

Generally, your therapist can provide information to a third party only if you give written permission to do so. Therefore, any time you give such permission, confidentiality is limited. No information pertaining to specifically-named clients will be shared among therapists without clients' written permission, except when another therapist is providing coverage during emergencies, vacations, etc. Therapists at Southside Counseling Center do occasionally engage in peer consultation, in order to provide clients with the highest caliber of service. In these cases and in most situations listed above, the therapist can reveal information only to someone who has a *need to know*, and entire records or irrelevant information may not be disclosed. Individuals entering therapy for reasons directly related to substance abuse have privacy rights in addition to those specified on this form. Whenever information will be shared with other persons, their names or positions will be specifically listed, and every effort will be made to ensure that the receiving person also maintains confidentiality. The

major situations in which the therapist may disclose such information with written permission are:

1. If a client is being evaluated or treated for a third party (disability, custody, etc.)
2. If a client requests or gives permission for information to be obtained from or provided to a third party (therapist, physician, teacher, employer, etc.)
3. If a client is using third-party coverage (insurance) to pay for therapy
4. In the event of the disability or death of a client's therapist

In addition to the above, I understand that special circumstances apply to group, couple, parent-child, and family therapy, as well as any time I may involve another person in treatment. *Basically, other individuals in the room are not bound by privilege and may possibly not hold all information confidential; the therapist is not responsible for disclosure by these individuals.* In situations where I am in therapy with another person (*e.g.*, a spouse or child), and secret information is revealed by one person to the therapist, it is understood that the therapist will not reveal the information (unless mandated by law), but may determine that it is not workable to continue treatment. Should this situation arise, the therapist will discuss it with me thoroughly.
It is this Center's policy that when minors participate in the counseling process, any parent(s) holding **legal** custody must sign this form, thus acknowledging and agreeing to participation by the minors involved. A legal custodial parent not participating in counseling with his/her children has limited access to privileged information, as the above-referenced rules of confidentiality apply. Minors entering therapy for the specified purpose of resolving substance abuse problems have additional privacy rights mandated by federal law.

I further understand that SCC employees assigned to schedule, record receipts from, and bill clients and third-party reimbursers have access to client records. Client records are stored inside locked cabinets within an office to which the public has no access. Billing and scheduling information are stored electronically; access is guarded by passwords and encryption software. By law, client records are kept for at least seven years; records remain the property of SCC. I may have access to my records after submitting a written request ($.50/pg photocopy charge), although it may be best for my therapist to discuss with me the items contained in those records or to provide me with a summary for a specific purpose.

Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require authorization. Any uses and disclosures not described in this notice will be made only with authorization from the individual.

I understand that I have a right to restrict certain disclosures of protected health information to a health plan for services for which I have paid out-of-pocket and in full, or for which another person has paid on my behalf.

Finally, I understand that I have a right to be notified if there has been a breach of <u>unsecured</u> protected health information.

Payment of Fees

I agree to pay my insurance co-pay <u>at each session</u> and to notify SCC immediately of any changes to my coverage. I understand that I am responsible

for, and I agree to pay, all charges not paid by my insurer. If I am not using insurance to pay for counseling services, my self-pay amount is due at each session. If I refuse to pay such charges, I agree that SCC has the right to suspend services until payment has been made. SCC retains the right to collect from me fifty dollars ($50) for any failure to attend session without prior notice or for cancellations occurring within 24 hours of my scheduled appointment. I also agree to pay SCC a fee of $75.00 per hour if documentation is required for a disability or legal claim.

If I demonstrate a recurrent pattern of late cancellations and/or no-shows for my scheduled appointments, I understand that my therapist may choose to refer me to another practice.

Client/Parent: ________________________________ Date: __/___/___

Client/Parent: ________________________________ Date: __/___/___

If signing for a minor- BOTH PARENTS MUST SIGN

Legal Non-Involvement Client Contract

Here at Southside Counseling Center, we believe that the nature and purpose of counseling are personal growth and change, and that counseling content and process should not be used as a legal tool against anyone. We never testify as expert witnesses, nor do we ever give professional opinion during testimony. At most, we can only reiterate what clients have said to us in session, to the best of our memory.

Therefore, no therapists or staff of Southside Counseling Center, LLC, will willingly become involved in legal action or appear in court on behalf of any client. If required to do so by means of subpoena, Southside Counseling Center, LLC will exercise the right to collect from the client $250 per hour for all time spent, including travel, wait-at-court and preparatory time. This hourly charge will also apply to all Southside Counseling Center, LLC client billable hours which are lost if a scheduled court date is cancelled or re-scheduled within 7 days of said scheduled court date. In addition, Southside Counseling Center, LLC has the right to collect from the client all legal fees which anyone from Southside Counseling Center, LLC incurs because of such involvement. Upon receipt of a subpoena to appear in court, Southside Counseling Center, LLC has the right to collect from the client $2500.00 in cash 7 days in advance of the scheduled court date, such funds to be held by Southside Counseling Center, LLC against actual costs incurred. These terms and fees are not negotiable.

In the event that client records are requested or subpoenaed, copying charges will be $.50 per page, payable by the client. We also reserve the right to charge the client $50 for any phone call (in excess of 10 minutes) which occurs at the request of a *Guardian ad Litem* or legal counsel.

By signing below, clients indicate that they have read and agree to these conditions.

__________________________________ __________________________________
Signature(s) (If signing for a minor, both parents must sign)

__________________________________ __________________________________
Printed Name(s) (If signing for a minor, both parents must sign)

____
Date

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SELF PAY RATES

As of June 1, 2017:

30-minute Sessions: **$50***
45-minute Sessions: **$75****
60-minute Sessions: **$100**

On January 1, 2013, new billing and coding policies for mental health facilities became effective nationwide. Among those changes was the addition of reimbursable 60-minute sessions. Our self-pay fees for 30 and 45-minute sessions are unchanged; however, we are adding a fee for sessions that last longer than 45 minutes, in accordance with the new third-party (medical insurer) policies.

By signing below, you acknowledge that you have been advised of and agree to the above policy.

I, ____________________________________ am fully aware of and agree to the above policy.

Client signature ____

Date __________________________________

*30-minute sessions which run over 30 minutes will be billed at the 45-minute rate.
**45-minute sessions which run over 45 minutes will be billed at the 60-minute rate.