COUNSELING FOR LIFE

ADULTS • ADOLESCENTS • CHILDREN

Welcome!

Thank you for choosing Counseling for Life for your therapeutic needs!

Please review the following office policies:

1. Please come into the waiting room and check in at the front desk. If the front door is locked, please call 864-353-3384 and leave a message; this will notify your clinician and they will be right out to greet you.

2. **Appointment Attendance**: Your appointment time is set specifically for you, so please notifiy the office 24 hours in advance if you need to cancel or reschedule. There will be a **one hundred dollar ($100)** missed appointment/last minute cancellation fee charged for all appointments in which 24 hour notice was not provided, the exception being symptoms of illness or lice. After two missed appointments in which no notice was given, no further appointments will be scheduled.

3. **Animals other than SERVICE DOGS are prohibited.** Please bring the animal's proof of current rabies vaccination to the first appointment if being accompanied by a service dog.

4. Our facility and premises are **smoke-free**.

5. Parking: Please let us know immediately if there is not adequate space.

6. The Fant Street office is open Monday through Thursday and our therapists' individual hours vary on those days.

7. The on-call clinician contact number for emergencies will be on the recorded message at 864-353-3384.

8. All court related work, including contact with attorneys or guardians, is billed at a rate of $225/hour and must be paid in advance.

9. Any and all fees not paid by insurance are your responsibility. Appointments will be suspended until outstanding balances in excess of $100 are paid in full. After two billing statements have been mailed and 120 days have passed, outstanding balances are turned over to a collection agency. All fees incurred to collect on unpaid balances are the responsibility of the patient.

I have read and agree to the above office policies of Counseling for Life.

Name of patient:_____ Date:_____

Signature of patient or custodial caregiver:_____

1209 N Fant St * Anderson, SC 29621 * PHONE 864-353-3384 * FAX 864-222-9715

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Patient Information Form

Date:_____

Legal Name:_____ **Preferred Name:**_____

Date of Birth:_____Social Security #:_____
Address:_____
City, State, Zip:_____
Preferred Phone Number:_____Email:_____
Alternate Phone Number:_____
Age:_____Gender: male female other
Relationship Status: single married divorced domestic partner other

Referral Source:_____Family Physician:_____

Employment Status: full-time part-time retired unemployed student
Employer Name:_____
City, State of Employer:_____Work Phone:_____

Emergency Contact_____Relationship to Patient:_____
Phone:_____

For Children:
Parent/Caregiver #1:_____Phone #:_____
Parent/Caregiver #2:_____Phone #:_____
School:_____Grade:_____

Please check one:

- o Self-Pay
- o INSURANCE

Subscriber Name:_____
Subscriber Address:_____
City, State, Zip:_____
Subscriber Date of Birth:_____Soc Sec #_____
Relationship to patient:_____Employer of Subscriber:_____
Name of Insurance:_____
ID#_____Group #:_____

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CLINICAL INTAKE FORM - CHILD

Today's Date: _____

Name:_____**Date of Birth:** _____

Gathering personal information about your child will help me to be as thorough as possible and meet your family's needs accordingly. Thank you for taking time to complete this form.

MEDICAL HISTORY -

Current medical problems: _____

Current medications (please include non-prescription medications): _____

Current supplements/vitamins: _____

Major traumas/hospitalizations: _____

Any head injuries?_____Any seizures?_____

Allergies: _____

Childhood illnesses: _____

Mother's pregnancy:

Under doctor's care?_____Substance use during pregnancy?_____

Complications during pregnancy or delivery?_____

Developmental History:

At what age did your child: Walk?_____Talk?_____ Toilet Train?_____

OTHER INFORMATION -

Who lives in the home with your child?_____

Who is the child close to emotionally?_____

What kind of discipline works best?_____

Anything else I need to know?_____

PRIOR COUNSELING/TREATMENT -

Has your child had counseling in the past? _____When? _____

Any history of mental illness in your family? _____

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Patient Name:_____ Date:_____

(For Children) Custodial Caregiver Name:_____

Informed Consent – Sandra Campbell, LPC

Welcome to Counseling for Life! Thank you for considering me for your therapeutic needs and please know I value your trust and your time. This document is required by law and by my licensing board. It is for your protection, so please read carefully as it describes your rights, the therapeutic relationship, cost of services, and rules and limits to confidentiality. Please feel free to ask questions after reviewing this document.

Professional Disclosure

I hold a Master's in Professional Counseling from Liberty University in Lynchburg, VA. I am a Licensed Professional Counselor in South Carolina (#6983) and I have been working in the counseling field since 2016. As a requirement for licensure, I continue to advance my knowledge base through further education.

I specialize in treating adults, adolescents, and children with mood, anxiety, and adjustment disorders, as well as depression, dual diagnosis, and trauma. My clinical experience also includes work with child survivors of sexual and physical abuse and maltreatment, adult survivors of sexual assault and autism spectrum disorders. I utilize Cognitive Behavioral Therapy as well as other therapeutic approaches, including EMDR.

If you have any questions or concerns, I hope you will discuss them with me. However, if you feel that I have been unethical or have not responded adequately, my licensing board may be contacted at:

South Carolina Board of Examiners
110 Centerview Dr
Columbia, SC 29211
(803) 896-4658

Confidentiality

I will keep the information you share with me in the strictest of confidence except under the following circumstances:
1. I must legally break confidentiality if I believe you are in imminent danger of harming yourself. I may contact the courts, family members, or emergency personnel. If I believe you are in danger of harming someone else, I must contact emergency officials and the intended victim(s). This is known as the "Duty to Warn."
2. I must inform the Department of Social Services and/or Law Enforcement if you share information with me about the abuse or neglect of a child or vulnerable adult. This includes substance use around a minor.
3. I will release any confidential information with your written consent. You may revoke that permission at any time.
4. Professional Counselors can be ordered by a judge to release confidential information.

Ethics

It is a privilege and responsibility to be your therapist. I take this opportunity extremely seriously and strictly adhere to the American Counseling Association's Code of Ethics, widely accepted in this field. The Code may be accessed at http://www.counseling.org/Resources/aca-code-of-ethics.pdf.

Specifically, the Code forbids breaking confidentiality except under the above outlined circumstances, prohibits sexual intimacy between practitioners and patients, and outlines other ethical guidelines for counselors.

Fees and Duration of Sessions:

It is customary to pay for professional services at the time they are rendered. We accept most insurance plans and we will file claims to your insurance company(s) on your behalf. You are responsible for paying the co-pay, coinsurance, and deductible at each visit.

Fees:

$210	-	Psychiatric Diagnostic Evaluation; 1-hour duration
$190	-	Subsequent sessions; 1-hour duration
$142	-	Subsequent sessions; 45-minute duration
$95	-	Subsequent sessions; 30-minute duration
$137	-	Self-pay Psychiatric Diagnostic Evaluation (35% discount)
$124	-	Self-pay 1-hour duration (35% discount)
$93	-	Self-pay 45-minute duration (35% discount)
$62	-	Self-pay 30-minute duration (35% discount)
$125/hr	-	All work outside the counseling session, including phone calls, billed to the minute
$225/hr	-	Bonding assessment, custody evaluation, court appearance and preparation, document preparation, document review, consultation, and all court-related work
$100	-	**Missed appointment fee/last minute cancellation fee**. This fee is not covered by insurance; please cancel your appointment 24 hours in advance to avoid this fee. **After the second missed appointment with no notification, further sessions will not be scheduled.**

_____(Please initial) I have read and understand the fee schedule.

Any and all fees not paid by insurance are your responsibility. Appointments will be suspended until fees in excess of $100 are paid in full. **After two billing statements are mailed and 120 days have passed, the outstanding balances are turned over to a collection agency.** All fees incurred to collect on unpaid balances are the responsibility of the patient.

If you have not contacted our office within fourteen days of a missed appointment, your case will be considered closed.

Appointments can be made by calling 864-353-3384. For after hour emergencies, please call 864-353-3384 and follow the instructions on how to contact the emergency on-call clinician.

Privacy is implied in medical settings. **Please do not use recording devices** in session without the counselor's knowledge. You will be discharged from the practice if you are found violating this policy.

Acknowledgment of Informed Consent and HIPAA Patient's Rights:

_____(Please initial) I agree that I have read and understand the preceding Informed Consent and the HIPAA Patient's Rights provided to me at my initial appointment. I have asked any questions necessary to fully comprehend these documents. I further acknowledge that I seek and consent to treatment by Sandra S. Campbell, LPC, for myself or on behalf of my minor biological or custodial child.

_____(Please initial) I agree to pay the designated fee at the time services are rendered, including co-payments, coinsurance, deductibles, returned check charges, and any and all fees associated with debt collection. I am aware that all non-court related work outside of session is billed at $125 per hour. All court-related work is billed at $225 per hour.

_____(Please initial) I agree to call 24 hours in advance to change or cancel an appointment or be subjected to a $100 charge. I will cancel appointments if I have experienced symptoms of illness in the past 24 hours, including lice (cancellations due to illness with less than 24 hours notice will not be charged).

_____(Please initial) I understand my rights and responsibilities as a patient and the limits to confidentiality. I understand that I can end therapy at any time or disregard any suggestions made by Sandra S. Campbell, LPC. I am over the age of 15 and sign this on my own or my custodial minor's behalf.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This document may be updated without notice so please review it each time you visit. A copy of this statement is always available upon request. All information revealed by you in a counseling session and most information placed in your counseling file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information ***cannot be distributed to anyone else without your expressed informed and voluntary written consent or authorization***. The exceptions to this are defined immediately below.

Use or disclosure of the following protected health information does not require your consent or authorization once you have consented to treatment:
(These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Counseling for Life, once you have provided consent. You may later revoke this authorization to stop any future uses and disclosures.)

1. Uses and disclosures required by law to law enforcement or court - for example, if you express intent of harming yourself or someone else (see "Duty to Warn" in the Disclosure Statement); court-ordered disclosures signed by a Judge; knowledge of the abuse or neglect of a child or vulnerable adult
2. Uses and disclosures for health and oversight activities – for example, correcting records or correcting records already disclosed; in case of emergencies; for public health purposes; or for research
3. Uses and disclosures for judicial and administrative proceedings - for example, in a case where you are claiming malpractice or breach of ethics
4. Uses and disclosures for Workers' Compensation - basic information obtained in a counseling session as a result of your Worker's Compensation claim
5. Uses and disclosures to obtain payment from insurance companies for counseling sessions – this includes, but is not limited to, your identifying information, diagnosis, treatment recommendations, determination of coverage, utilization review activities
6. Uses and disclosures related to implementation of services – for example, a sign-in sheet may be used in the reception area; you may be called by name for your appointment in the reception area; you may be called at your contact number to remind you of an appointment; text messages for appointment reminders
7. Uses and disclosures related to support services for Counseling for Life – protected health information may be shared with business associates to perform billing or other support services; however, a written contract will be in place containing terms that will protect the privacy of your protected health information

Your Rights as a Counseling Patient under HIPAA:

1. As a patient, you have the right to see and receive a copy of your counseling file. Copying fees are $0.65/page for the first thirty printed pages and $0.50/page therafter. Psychotherapy notes, however, are afforded special privacy protection under HIPAA regulations and are therefore subject to some exclusions.
2. As a patient, you have the right to request amendments to your counseling file.
3. As a patient, you have the right to receive a history of all disclosures of protected health information.
4. As a patient, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish to be disclosed.
5. As a patient, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Name of patient:_____ Date:_____

Signature of patient or custodial caregiver:_____

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FAX PRIVACY WAIVER

I, _____ , date of birth _____ , understand that my records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve Counseling for Life, Inc., of all liability.

_____**(Please initial)** I give my consent to fax my records for the purposes of treatment, payment, or other healthcare needs and understand that I may withdraw this consent at any time in writing.

TECHNOLOGY WAIVER

_____ **(Please initial)** I give my consent to receive text messages and emails from Counseling for Life, Inc. I understand that these are not secure communications and by signing below, I absolve Counseling for Life, Inc., of all liability.

_____

Patient, Parent, or Legal Caretaker Signature Date

_____

Printed Name

_____

Witness Signature Date

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Patient Credit/Debit Card Form

All patients are required to keep a valid credit or debit card on file.

For your convenience, this card will be used after services are rendered unless you choose to pay with check or cash at the time of your appointment. This card will also be used for tele-health appointments, outstanding balances, no-show fees or cancellations with less than 24 hours' notice (illness and extenuating circumstances being the exceptions).

All credit card information will be kept confidential and in a secure location.

Credit/Debit Card Type: MasterCard VISA Discover AmEX

Name on Card:_____

Card Number:_____

Expiration:_____CVV Code:_____

Zip Code:_____ Email address for receipt:_____

"I, _____ (print name) have read and understand the terms of providing my credit/debit card information to Counseling for Life, Inc. **I understand that my card will be charged unless I pay with cash or check at the end of each session**, for telehealth sessions, for no-show or late cancellations ($100), or for outstanding balances. Any questions I have about this agreement have been answered and I authorize this card to be charged for the reasons outlined above."

_____

Patient Signature (or caregiver on behalf of minor) Date

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