Counselor: Barbara Becherer, LPC, RPT-S Tel: 314-623-7575 Fax 636-412-7990

CLIENT INFORMATION -FINANCIAL RESPONSIBILITY – INFORMED CONSENT

Client Name (CL)		Hm Tel		Cell	
Address		City		zip	
Cl DOB		Age		M		F		Client's SS#		email	
Indicate where it's Ok to leave a message	Hm tel		cell		Text		email		other	

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COMPLETE FOR MINOR CLIENTS ONLY include Birth parents/ adopted parents of client					
Mother's name		DOB		Tel	
Father's name		DOB		Tel	
Who has legal custody of client					
Who has physical custody of client					

If there is a custody agreement: Legal custody agreement for minor child is required before counseling begins

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Briefly state what you want to work on in counseling	

Emergency Contact		Tel		Relationship to cl	
Primary Care Physician		Tel		Fax #	
Do you want counseling coordinated with doctor	yes		no		If yes indicate doctor name ,fax & tel # if diff than above

If Client have more than 1 insurance complete info for primary and secondary insurance							
PRIMARY INSURANCE NAME				Tel			
ID#		Group #		Deductible amt		copay	
If authorization required #		# session approved		Beg date		End date	
Policy holder's name if not CL				DOB		SS#	
Policy holder's address if diff than CL				Tel		cell	
Policy holder's employer		tel					

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SECONDARY INSURANCE NAME				Tel			
ID#		Group #		Deductible amt		copay	
If authorization required #		# session approved		Beg date		End date	
Policy holder's name if not CL				DOB		SS#	
Policy holder's address if diff than CL				Tel		cell	
Policy holder's employer		tel					

Release of Information With my signature I as the client or guardian authorize any holder of medical and other information about me or my child as it pertains to my health care; to release all needed information to determine benefits payable, process my claims, or to collect the fees for counseling.

***Assignment of Counseling* Benefits** With my signature I hereby assign and request that all third party payments be made directly to Barbara Becherer.

Future Authorizations for Sessions With my signature I authorize Barbara Becherer, LPC to complete the necessary paper work to request additional sessions from my health insurance or third party payer, when additional sessions are needed.

Acknowledgement of Receipt of Notice of Privacy Practices You are hereby notified that you may review the **NOTICE OF RIVACY PRACTICES**, which explain when, where and why my confidential health information might be used or shared. I understand that Barbara Becherer, LPC may share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Barbara Becherer's operations and responsibilities.

	I choose NOT to receive a copy of the Notice of privacy practices
	I choose TO receive a copy of the Notice of privacy practices

Client Rights

- Knowledge of counselor's education and training
- To be fully informed of the conditions under which services will be provided
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- Discuss your counseling with the persons that you choose
- Request information regarding a form of counseling used in your treatment
- Review your file and or have summaries of your file released to other professionals with your written request
- End counseling at any time, hopefully after you have discussed your reasons with this counselor, unless of course you are mandated to attend counseling. By ending counseling without discussing it keeps someone else from receiving needed counseling services
- The right to ask questions about your counseling

Confidentiality Policy

Personal information shared with Barbara Becherer, LPC is confidential and all reasonable precautions will be taken to maintain confidentiality while you are in my care. There will be no recording of the session by either party unless requested in writing. There are, however, some limitations to confidentiality that may require the disclosure of information as follows:

1. **Abuse or neglect** – Missouri state law requires all therapists to report suspected physical or sexual abuse, or neglect of children or elderly adults.
2. **Threats** – We report serious threats of physical harm to self or others.
3. **Education, Research and Peer consultations** – For the purpose of professional supervision, research, and peer consultation sessions may be videotaped, pictures may be taken of therapeutic work and cases may be reviewed and discussed.
4. **Third Party Payments** – When you use a 3rd party payments, like insurance Barbara Becherer, LPC, will be required to disclose specific clinical information (i.e. diagnoses) to the insurance company in order for you to receive payment.
5. **Court order** – A judge in a court of law may require the disclosure of specific information pertinent to a case before the court.
6. **Written Permission** - If you give me written permission to release information to another party.
7. **Criminal Activities** - If you have revealed criminal activity or information

Social Media – Due to client counselor confidentiality and ethical standards Barbara does not accepts confidential messages on social media.

During session is it expected that telephones and electronic devises will be turned to silent and client will not talk on the telephone or text.

CHILD / PARENT CONFIDENTIALITY Barbara Becherer, LPC strongly encourages parent participation in all phases of child treatment. At the same time, specific details of the information provided by children is not shared with parents in an effort to encourage children to be as honest and forthcoming as possible, and to maintain an emotionally safe environment for them. Note that we do not discourage children from sharing information with their parents but we ask that instead of asking your child for information that you allow your child to volunteer the amount and kinds of information that they are ready to share. I usually encourage them to do so when they are ready as part of the therapeutic process.

During my counseling I understand that Barbara Becherer, LPC makes no guarantees as to the results of treatment or evaluations. The counseling process is one in which you seek to understand yourself, your feelings more clearly and perhaps, to make some changes in your life as a result of what you have learned. My role in counseling is a facilitator for your self-understanding and or changes. You will aid yourself in this process by being honest and open with this counselor. Occasionally Barbara may say things that are hard for you to hear. Because the counseling process includes exploration of aspects of yourself that have been previously hidden you may be surprised by the intensity of new emotions. Be assured this is part of the healing process which may occur during counseling.

Please be aware that my policy is to not testify or get involved in custody or other court issues due to the concerns of damaging the therapeutic relationship. I do not participate in custody evaluations and if a custody situation arises you will be referred to your insurance company to obtain a professional that specializes in custody evaluations.

Client's Responsibilities and Agreements (please read this part carefully)

I agree to the following: Arrive on time for my appointments

- That I am responsible to pay for sessions that are not covered by a third party
- Notify Barbara of any changes in Name, address, tel #, insurance company and or benefits
- I will work with Barbara to develop a counseling plan and I will follow that plan
- All Information provided is true and accurate
- Give Barbara a 24 hour notice for appointment that I need to cancel.

I agree to pay a cancellation fee **for missed sessions that I have not given a 24 hour cancellation notice. I understand the amount of the cancellation fee will equal the amount my insurance or third party payer**

would allow for the missed sessions.

***I also understand that I am required to have a credit card on file with Barbara Becherer, LPC and Associates* I give permission for Barbara Becherer, LPC and Associates to charge my credit card for the missed sessions that I did not give a 24 hour cancellation notice. I agree that I keep a current credit card on file with Barbara Becherer LPC and Associates**

Name on Credit Card						*Credit card No*			
visa		*Mcard*		*other*		*Expiration date*		*code on back of card (3 #s)*	

I further agree that Barbara Becherer LPC and Associates can make a copy of the above credit card to keep on file. I understand that my credit card information will be kept in confidentiality along with all of my counseling records.

- **I understand that 2 missed sessions without 24 hours' notice will be grounds for Barbara Becherer LPC and Associates to discontinue services.**
- **I understand that my cancellation without a 24 hour notice keeps Barbara Becherer LPC and Associates from seeing other clients in need of services and this is the reason for the cancellation fees.**

- I will keep my calls to Barbara Becherer, LPC and Associates between 9 am – 6 pm Monday - Friday unless except for true emergencies**.**
- If I chose to communicate with Barbara Becherer LPC and Associates via email or other types of social media I will not hold her accountable for any breaches on confidentiality that may take place due to the use of these services**.**

__________Please initial that you have read and agree to the Client Responsibilities listed above.

FEES FOR SERVICES

- All co pays and deductibles are due at the beginning of each session
- Letters and reports will be provided with written request at the rate of $35 each and copies of files or information will be provided at the current rate allowed
- Fees for services: Intake **$150**, Office **$100**, outside office $150, Letters And **reports $35** per page
- All telephone calls for more than 15 minutes in length will be charged to you at the rate of $90 per hours and billed in 15 minute increments.
- Unpaid fees associated with counseling may be turned over for collection you will be responsible for fees associated with that collection.

- Fee for copies of files .40 a page with minimum of a $15.00 charge. This includes copies given to the client as well as copies of file gives to parties as the client requested.

________ PLEASE INITIAL THAT YOU HAVE READ AND GREE TO THE FEE FOR SERVICE

Agreement for Minors

- I hereby agree not to subpoena Barbara Becherer, LPC and Associates for testimony or ask for copies of my child's records or evaluations from Barbara Becherer, LPC and Associates.
- I will not request access to any of Barbara Becherer LPC and Associates documents or records pertaining to my child, but I will instead meet with Barbara to discuss my child's progress.
- I am the Financially responsible party and I have legal custody if said client is a minor

The undersigned certifies that I have read the statements on page 1 through 3 of this document and that I agree and accept the terms herein. I agree that I am financially responsible for all fees that are not covered by a third party and if at any time I do not pay those fees on a timely basis I will be responsible for the fees required to collected said counseling fees.

Signature client/guardian____ **Date** __________________

Signature witness ____ **Date** __________________

CLIENT COPY

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Signature witness ____ Date _________________