Lighthouse Christian Counseling
410-758-4800
Lighting the Way to Hope and Healing

CONSENT FOR SERVICES, POLICIES, AND FEE AGREEMENT

Welcome to Lighthouse Christian Counseling. We are pleased you have chosen us for services and will do everything possible to help make your experience positive and helpful. Please read the information below, sign and date the form. We welcome any questions you may have. Thank you.

OFFICE HOURS

Our office hours are from 9:00 a.m. to 5:00 p.m. Monday through Friday. We ask you to call during regular hours whenever possible. If you leave a message and we haven't gotten back to you within 24 hours, please assume we have been unable to connect with you and call again. Phone conversations of a therapy nature that last longer than five minutes will be charged at the regular therapy rate.

CRISIS SITUATIONS

Lighthouse Christian Counseling is not a crisis facility. If a life threatening or other crisis situation arises, please take the following steps: (1) call 911, (2) call Oasis after hours clinic 410-571-0888 or go to the nearest emergency room, (3) call your counselor to make them aware of the situation.

SCHEDULING APPOINTMENTS/CANCELLATION/NO SHOW POLICY

Scheduling appointments is your responsibility and is generally done jointly with your therapist. For the consideration of your therapist and other clients, you are expected to keep scheduled appointments or cancel at least 24 hours in advance. If you do not attend nor cancel an appointment with your therapist at least 24 hours ahead of the appointed time, you will be charged for the missed session, which is not covered by insurance. Allowances are made for emergencies. 1ST no show or less than 24 hour cancellation: $45.00, 2nd no show or less than 24 hour cancellation: $60.00; 2nd no show or less than 24 hour cancellation: Full fee.

COUNSELING/THERAPY SESSIONS

Therapy sessions usually last 45 to 50 minutes. Their frequency will be determined between you and your therapist according to your need. Group therapy sessions are usually 60 minutes to two hours in length depending on the type of group and generally meet for a specified period of time. Parents who bring their children to LCC are responsible for their supervision at all times in the waiting room and/or the property at large.

NOTICE OF CONFIDENTIALITY AND LIMITATIONS

Federal and state laws and regulations protect the confidentiality of mental health records maintained by us. Violation of such is a crime. No information is released to any source outside the agency without your written permission or a court order, a medical emergency, or audit. Crimes committed against the LCC staff, property, or threats of crimes are not protected by confidentiality laws. Suspected child/elder abuse or neglect is not protected and must be reported to proper authorities. If you have questions or concerns about confidentiality, please discuss these with your therapist. You will also be provided with a Notice of Privacy Practices that covers how your health information is used and disclosed.

****PARENTS OF MINOR CLIENTS:** It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint. Because the therapeutic relationship is vital to change and support, we discourage parents to include the counselor in any court proceedings involving the children as clients. At this time we do not provide child custody evaluations.

****CONFIDENTIALITY FOR COUPLES/FAMILIES/GROUPS:** Discuss with your counselor how you will handle spouse phone calls, scheduling, or individual sessions and the limits of confidentiality where couples, families and groups are involved.

CANCELLATION/NO SHOW POLICY

Insurance will not reimburse for missed appointments, and these charges are your responsibility.

FEES AND PAYMENT

All co-pays are due at the time of service. We accept Visa, Master Card, cash or check made payable to Lighthouse Counseling. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. Our current fee per session is $130 for the first diagnostic session and $115 for sessions thereafter. If any or all outstanding balances are not paid, Lighthouse Counseling reserves the right to release a client's name and address to a collection agency. Also, a monthly interest fee of 2% will be charged for these balances until they are paid in full. LCC will bill your insurance company for all sessions unless otherwise agreed upon. Please note that you are responsible for payment in cases when your insurance company does not pay for our services.

LEGAL PROCEEDINGS: I also understand that my therapist may be required to become involved in legal proceedings involving my therapy (or my child's therapy if that applies). In that case, I agree to pay for the therapist's time, as listed in the

fees schedule ($400.00/first hour). This includes preparing for such legal action, including, but not necessarily limited to, traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of my involvement in such legal action. **This fee is due one week prior to the court proceeding. Additional fees will incur for each additional hour the therapist is required to be retained at court. These fees will be billed to client and payment expected within 30 days.**

CLIENTS USING INSURANCE – INSURANCE AUTHORIZATION

I, _____,
hereby authorize payment of medical benefits to Lighthouse Christian Counseling for services received. I also authorize the release of any information necessary to process claims. I understand that: I am responsible for all co-pays, deductibles, and any fees unpaid by insurance for any reason; that Lighthouse Christian Counseling only bills for primary insurance coverage, not for secondary coverage; and that I am responsible for understanding my benefit plan and will inform Lighthouse Christian Counseling of any changes in my insurance coverage, including the termination of any coverage. When insurance coverage terminates or an annual limit is reached I will arrange to pay for services out-of-pocket if I decide to continue counseling.

X_____Date: _____
Client Signature (Parent/Guardian if minor)
X_____ Date: _____
Client Signature (2nd Parent/Guardian if minor)

NON-INSURANCE CLIENTS – SLIDING FEE ADJUSTMENT POLICY

Thank you for choosing Lighthouse Christian Counseling for your counseling needs. Your counselor has agreed to see you for a reduced fee of $_____
I have read and understand this agreement and have had the opportunity to ask questions about it. I agree to pay at time of service the amount listed above for therapy sessions, in addition to other charges in connection with my treatment, as listed above. If my financial circumstances change, I will promptly advise the Clinical Director at (410) 758-4800.

X_____ Date: _____
Client Signature (Parent/Guardian if minor)

CONSENT FOR TREATMENT OF MINOR CHILD

I, _____, give Lighthouse Christian Counseling _____

(counselor) permission to provide treatment for _____(minor child).

X_____ Date: _____
Client Signature (Parent/Guardian if minor)

CONSENT FOR PARTICIPATION

I authorize Lighthouse Christian Counseling to provide the following: diagnostic assessment, outpatient psychotherapy/counseling. My participation is voluntary. I understand that my treatment plan will be individualized to meet my needs and goals. I will participate in the development of my treatment plan and keep my account current. I have received a copy of this form.

_____

Signature

_____

Date