# InPowerment Incorporated

**Natolie Gray, MA, LPC**

## THERAPY SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business polices. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

It is important to note that services can be emotionally and psychologically challenging, even painful. Sometimes you may feel worse before you feel better. On the other hand, counseling and psychotherapy have also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**MEETINGS**

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 to 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

**PROFESSIONAL FEES**

My hourly fee is $110 for the initial consultation and $100 for ongoing sessions. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records

or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

**BILLING AND PAYMENTS**
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided and the amount due.

**INSURANCE REIMBURSEMENT**
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payments of your fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call the plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Manage Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become a part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over with they do with it once it is in their hands. In some cases, they may share the information with a national medical information data-bank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run

out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

**CONTACTING ME**
I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you are available. If you are unable to reach me and feel that you can not wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**PROFESSIONAL RECORDS**
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

**CONFIDENTIALITY**
In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions: information you and your child report about physical or sexual abuse; information shared with your insurance company to process your claims; where you sign a release to have specific information shared; if you provide information that informs me that you are in danger of harming yourself or others. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

By signing this agreement, you agree to the terms and conditions outlined herein and have had the opportunity to ask questions and/or discuss concerns

_____ _____
Patient/Guardian Signature Date

## CLIENT INTAKE FORM: COUPLES

Date _____

### General Information – please print

Referred by (if internet, which site/s?)

_____

If a personal/professional referral, may I thank the person? ❑Yes ❑No

**Client I**

Last name _____ First name _____ MI _____
Birth date _____/_____/_____ Age _____
Street Address

_____

(street) (city) (state & zip)

| | Preferred | Ok to leave message? |
|---|---|---|
| Cell phone _____ | ❑ | ❑ |
| Home phone _____ | ❑ | ❑ |
| Work phone_____ | ❑ | ❑ |
| Email address _____ | | ❑ |

Place of Employment_____
Length of Employment _____
Type of work you do_____

Highest level of education completed: ❑ High School ❑ College degree ❑ Graduate degree
❑ Professional training ❑ Other _____

*In case of emergency, contact* _____

Relationship _____Emergency phone _____

**Client 2**

Last name _____First name _____ MI _____
Birth date _____/_____/_____ Age _____ Sex: ❑ Female ❑ Male
Street Address

_____

(street) (city) (state & zip)

| | Preferred | Ok to leave message? |
|---|---|---|
| Cell phone _____ | ❑ | ❑ |
| Home phone _____ | ❑ | ❑ |
| Work phone_____ | ❑ | ❑ |
| Email address _____ | | ❑ |

Place of Employment_____
Length of Employment _____
Type of work you do_____
Highest level of education completed: ❑High School ❑College degree ❑Graduate degree
❑Professional training ❑Other _____

*In case of emergency, contact* _____

Relationship _____ Emergency phone _____

Relationship status: ❑engaged ❑married ❑partnered ❑living together ❑separated

Length of time married/partnered (or length of relationship): _____

Others living in your home (Names/Relationship/Age):

_____

Children not living in your home (Names/Ages): _____

_____

## Counseling Concerns

What is the major problem?

Client 1: _____

_____

Client 2: _____

_____

How long have you had this problem?

Client 1: _____

_____

Client 2: _____

_____

When else have you had similar problems?

Client 1: _____

_____

Client 2: _____

_____

Why are you seeking help now?

Client 1: _____

_____

Client 2: _____

_____

What would you like to see happen as a result of therapy?

Client 1: _____

_____

Client 2: _____

_____

## Medical and Psychological History

Have you received psychotherapy or counseling in the past? ❑ No ❑ Yes
If so, when and with whom? _____
_____

Client 1:
List physical illnesses or symptoms:

_____
_____
Physician's/Psychiatrist's name(s) and phone number(s):

_____
_____
List current medications: _____
_____

Client 2:
List physical illnesses or symptoms: _____
_____
Physician's/Psychiatrist's name(s) and phone number(s): _____
_____
List current medications: _____
_____

Have either of you received help for drug or alcohol dependency?
❑ No ❑ Yes
Who?_____ When? _____ For what?_____
Where?_____

Have either of you been hospitalized for mental/emotional/psychiatric reasons?
❑No ❑Yes Who?_____ When? _____
For what? _____ Where?_____

## Other

Please provide any other information you think will be necessary or helpful:

_____

# InPowerment Incorporated

**Natolie Gray, MA, LPC**

## AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Natolie Gray, 440 South Perry Street, Lawrenceville, GA 30046
To release and disclose information from the clinical record of:

_____
(Name of client/recipient of mental health services) (Date of birth)
to, and allow such information to be inspected and copied by:

_____
(Facility/Provider)

_____
(Address)

Nature of information to be disclosed: _____
(State specific nature of information to be disclosed)

For the purposes of:_____
(State specific purpose of information to be disclosed)

I understand that I may revoke this consent at any time. This authorization is valid until _____.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _____ no information released and/or _____.

A copy of this release shall have the same force and effect as the original.

_____ _____
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

_____ _____
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

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## INTAKE INFORMATION

PATIENT'S NAME_____
FIRST INITIAL LAST

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ PATIENT'S BIRTH DAY_____

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### INSURANCE INFORMATION

INSURED'S NAME AND ADDRESS_____
SS#_____ DOB_____
INSURANCE COMPANY _____
GROUP NO. _____ INSURED'S EMPLOYER_____
WORK NO. _____ REFERRAL SOURCE_____

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**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist and b) information you report about child physical or sexual abuse; then, by Georgia State Law, I am obligated to report this information to the Georgia Department of Children and Family Services, c) information shared with your insurance company to process your claims, d) where you sign a release to have specific information shared, e) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Natolie Gray will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____Date_____

**Financial/insurance issues:** As a courtesy, we will bill your insurance company, HMO or responsible party if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds, $300.00, we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect he debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to InPowerment Incorporated. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, Please feel free to ask.

Signature(s)_____ Date_____