Client Information	
Full Name:	
Date of Birth:	Age:
If this is an appointment for a child, please provide the name of the parent(s) or person with whom the child resides:	
Who has legal custody of the child?	
Address:	
Home Phone:	Mobile Phone:
Email Address:	
Who referred you to Ms. Chambers?	

BUSINESS POLICIES AND CLIENT AGREEMENT

Welcome to my practice! Thank you for entrusting me to help you with your concerns. It is my hope that I will provide a safe and trusting relationship in which you may work through your concerns and feel more hopeful. This agreement contains information about my professional services and business policies. It is asked that you review and sign this document before coming to your first appointment. Please read carefully, and sign and date the last page. Taking care of the business policies ahead of time allows me to focus on you when you arrive for the first session.

Potentials, LLC, is a collaborative of three independent practices, including Shelley Chambers, LCSW, PC; Hook Psychological Services; and Rigby Psychological Services. To provide you with the best care possible, we consult with one another when clinically advisable. If I am out of town or for some reason unavailable, it is important that my partner clinicians of Potentials have access to relevant information to provide the best possible care to you and/or your family.

Therapy/Counseling: It is hoped that our professional relationship will be one where you receive the maximum benefit. Psychotherapy may be tremendously beneficial while, at the same time, it is important to know that there may be an increase in all feelings including feelings such as sadness, anger, guilt, fear, or anxiety. Please remember that these feelings may be natural and an important part of the therapy process. When the "client" is a child, it is important for the parents/guardians to share any changes in behavior, mood, or routines following therapy so that I will know the best way to work with the child in therapy. Depending on the age of the client, therapy may look different. For example, when the "client" is a child, therapy may involve play therapy sessions for the child, consultation & coaching for their parents or caregivers, and family therapy. For adults, therapy may be individual therapy or couples therapy for relationship related concerns.

Wellness Services: Wellness services include workshops, trainings, group sessions, and individual coaching sessions to promote optimum well-being. I will draw from my training and experiences to help you put your dreams into achievable goals. Insurance is not accepted for wellness services because I will not be identifying or treating a mental health diagnosis. I honor the time you have devoted to creating a more fulfilling life and will partner with you to develop strategies to help you reach your personal or professional goals.

Initial Contact: The first appointment is a time for you to discuss your concerns, provide background information, as well as a time to develop a plan for therapy. When children are in therapy, the child's parent(s) or guardian(s) are involved in the treatment and their participation is expected. Parents generally attend the initial appointment without the child, especially if the child is very young, so that parents may share their concerns candidly without the child hearing their parents' worries. At no point in therapy may children be dropped off for therapy.

Confidentiality:

Minors & Parents: In the state of North Carolina, children less than 18 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be shared with parents or guardians.

Children & Treatment Consent: To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, my services fall under this, and you may be in violation of a court order if you fail to inform the other parent of my services with your child. By signing this form you are stating that you have the legal right to consent for this child's treatment.

Confidentiality & Clients' Rights: Confidentiality is your expectation that the information you disclose to me will be kept private, including the fact that you consult with me at all. Please note that I may discuss cases in peer supervision, and by signing you give permission for these discussions, when consultation is to aid me in providing effective therapy. Peer supervision is clinical consultation with another clinician at Potentials who is also bound to keep client information confidential. As a general rule, outside of peer supervision, I will not disclose information regarding a client unless authorized to do so by the client in writing. One exception to this is if I employ outside services to collect past due accounts; by signing this form you give permission for such disclosure if necessary. There are also legal exceptions to confidentiality; these are described in the attached Notice of Privacy Practices, The Health Insurance Portability and Accountability Act. HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging I have provided you with this information; by signing below you are certifying that you have been given a copy of the Notice. You may revoke this Agreement in writing and that will be binding unless: s/he has taken action in reliance on it; if there are obligations imposed on the clinician by your health insurer in order to process or substantiate claims; or if you have not satisfied any financial obligations. Please understand that all files are kept confidential. Your written consent is required for any release of information. There are important exceptions to confidentiality that are legally mandated. Exceptions include: (1) If I believe the client intends to harm himself or someone else; (2) if I suspect child abuse, elder abuse, or neglect; and, (3) if court ordered to share confidential information.

Request for Records: Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining that trust. By signing this agreement, you will be waiving your right to access you or your child's treatment records except for treatment summaries provided upon request. If I am required to testify, a judge may order me to produce records. A subpoena signed by an attorney will not be enough for us to release your child's therapy records.

Phone Messages: During regular office hours calls are answered by office staff or me, when not in session. In the evening, calls will go to voicemail. I attempt to return calls within 24 hours. However, if you call and do not receive a call back within 24 hours during the work week, please call again. If you leave a message to cancel an appointment, I will leave it up to you to call back when you are ready to reschedule.

Email: I prefer to use emails primarily for office procedures, billing practices, or administrative matters. Potentials has a general office email address but please do not use it for content related to therapeutic matters. Emails should contain non-urgent matters only. If you are experiencing an emergency my private voice message has information on how to contact me after hours. If it is a dire emergency, call 911 or go to the closest emergency room.

Friending and Text Messages: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). As a general rule, I do not accept text messages. Adding clients as friends on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Ending Therapy: Ending therapy may occur at any time and be indicated by either the client or the therapist. If you are unhappy with therapy, please share your concerns and perhaps changes can be made to make therapy more helpful to you. Generally, therapy ends when you have accomplished the goals you established at the beginning of therapy. If you stop attending sessions, I generally do not call out of respect for your choice. Do not interpret not receiving a call as me not caring about you. If you decide at a later date that you are ready to become involved in therapy again, please feel free to call and ask to resume therapy. I understand that sometimes it is just not the right time to devote the energy necessary for successful therapy.

Rates:

All payments are due at the beginning of the session

Service	Rate
Initial Interview (Intake)	$ 150
Subsequent Interviews, Therapy, Wellness, or Co-parenting Sessions, per 50 minute session	$ 150
Additional time, per 15 minute increments	$ 50
Telephone Consultation, per 15 minutes or any portion thereof	$ 50
Any other service performed on behalf of client such as letter writing, completion of forms, 15 minute increments	$ 50
No show fee	Full rate of scheduled appointment
Court preparation/testimony	$ 2000 or $300 per hour, whichever is greater
Affidavit Fee	$500 or $300 per hour, whichever is greater
Clinical Supervision	$100 per hour

Complete this portion if you plan to file for payment through Blue Cross Blue Shield. Insurance does not cover co-parenting sessions. Insurance only covers mental health services that are medically necessary.

Co-payments and Deductibles: All co-payments and deductibles must be paid on the day of your appointment at the beginning of the session. This arrangement is part of your contract with your insurance company. Failure on our part to

collect co-payments and deductibles from clients can be considered fraud. Please help me in upholding the law by paying your co-payment or paying toward your deductible each visit. Knowing your insurance benefits is your responsibility. **Please verify your benefits before coming to the first appointment.** Generally, you will find a 1-800 number on the back of your insurance card to obtain your benefit information. Please ask your insurance representative if outpatient counseling is covered by your plan and whether you will be paying a co-pay or paying towards a deductible.

Insurance Information:

Client's Name: _____

Insurance ID #:_____

Insured's Name: _____

Insured's DOB: _____

Relationship to client: (parent, grandparent, guardian) _____

Copay (if applicable): _____ Deductible amount (if applicable): _____

Number of therapy sessions covered per year: _____

Cancellations and no-shows: There is a charge for missed appointments and appointments cancelled with less than **48 hours notice**. This charge is the sole responsibility of the client. Clients who do not show for two scheduled appointments will not be rescheduled. Clients are most successful in therapy when they find a way to make it one of their priorities, and committing to a set schedule helps clients to prioritize this time for personal growth. The full fee is charged for intake, therapy, and consultation appointments that are missed or cancelled less than 48 hours in advance. However, there will be no charge if: (1) you are ill, (2) you experience an emergency, (3) driving conditions are hazardous because of inclement weather.

Other services: All other services, including phone calls, letters, telephone consultation, meetings attended on your behalf and at your request (including travel time) are billed at the rate of $50 per 15 minute increment. Insurance does not cover these services. Late Fees & Returned Checks: The returned Check fee is $30. For therapy, if you do not pay in full on the date services are rendered and no prior arrangements were made, 10% of the original charge will be added each week you are late. Regarding delinquent accounts, you are responsible for in full and will be charged for in full any and all time we spend trying to collect on the account (billed at our hourly rate), and/or any and all fees of any outside services, such as a credit collection company or attorney, hired to collect the debt.

Testifying: Participating in court for custody or any other matter is not an expected service. Should I be subpoenaed, the rate is $300 per hour or $2000 total, whichever amount is greater, for all time related to responding to the subpoena regardless of whether I am called to testify. This may include time reviewing notes and talking with attorneys, as well as any phone calls or letters written on your behalf. If required to appear in court, I must cancel all other clients for that day, even when placed on "stand-by" status. You will be charged for the entire day. The rate is the same for depositions of fact or expert witness, as well as testimony. The party sending the subpoena is responsible for the entire bill. Preparing an affidavit will cost $500 or $300 per hour, whichever is greater.

Separation/Divorce Policy: The parent who initiates services with me is held financially responsible. I do not bill another person or an estranged spouse unless we are notified in writing of his or her willingness to pay for rendered services.

Informed Consent: Please sign below to indicate that you have read the preceding information in full, and understand the information. If you would like, I am happy to read the forms and review them with you. Please ask for clarification of any information that is confusing. Your signature indicates that you have read the document and agree to the terms of our professional relationship.

I have read and understand the policies and agree to the conditions. I agree to the statements herein and terms of payment, to include payment of all fees listed. If the client is a minor, I certify that I have the legal right to consent to treatment. I acknowledge receipt of HIPAA Notice of Privacy Practices. If we are assisting you in filing insurance claims, I also authorize Shelley Chambers, LCSW, PC, *to release any and all information to assist in filing my claim. I understand that by signing this page I do not need to sign subsequent claims. If the claim is denied, I agree to pay the balance in full. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. I authorize payment of benefits for therapy or assessment to Shelley Chambers, MSW, LCSW for services rendered.*

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Signature *Date*