Thomas Mullens Counseling, PLLC
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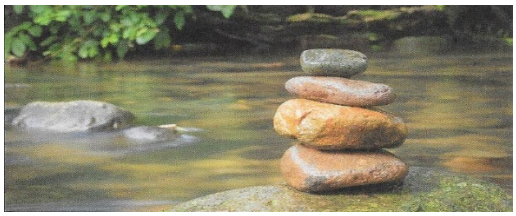
616-403-0783
Thomasmullenscounseling@gmail.com



"Bringing Life Back Into Balance"

Today's Date: _____

Client Full Name: _____ Preferred Name: _____

Home Address: _____ Date of Birth: _____

_____ Age: _____ Gender: _____

_____

Cell Phone: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Preferred Appointment Reminders: Home: ____ Work: ____ Cell: ____ E-mail: ____

Contact Person if different than client: _____

Emergency Contact Name: _____ Phone: _____

Relationship to the client: _____

How did you find or hear about this office? _____

If someone other than the client will be financially responsible for this account, indicate here:

Other Responsible Party: _____ Phone: _____

Address: _____

Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Employer: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Employer: _____

The above information is accurate and complete to the best of my knowledge:

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

An adult client is considered responsible for his/her own account. The reponsible party for a minor account (under age 18) rests with the parent seeking services. If client is a minor child, responsible adult seeking services:

Parent Name: _____ Telephone Number: _____

Date of Birth: _____ SS #: _____ _____ _____

List all medications: _____

Other Mental Health Providers: _____

Appointment Reminder/ Confirmation Calls

- I request Thomas Mullens Counseling staff to make reminder contact with me prior to appointments.
- By signing here, I consent to receive reminder calls, texts or e-mails as indicated on the previous page.
- I understand that the time and location of my appointment may be communicated to anyone answering my telephone or left on my answering machine/voice mail.
- I also understand that reminder calls are a courtesy and may occur if I am late or miss an appointment.

_____ _____
Signature of Client/ Parent/ Legal Guardian Date

Telephone Information

- If there is a mental health emergency, please call 911 or go to the nearest emergency room.
- Should there be an **URGENT** need to speak with your therapist after hours, call 616-403-0783 and we will work to reach your therapist if at all possible.
- Please be advised that there will be a regular session fee charge based on the minutes used; these are often not billable to insurance.
- I understand that there are **fees associated with phone calls to my therapist** and I will be personally responsible for those charges

_____ _____
Signature of Client/ Parent/ Legal Guardian Date

Punctuality and Attendance

When you make an appointment, your mental health professional will reserve that time for you. It is your responsibility to keep the appointment and to apply yourself wholeheartedly to benefit from each session. Frequent cancellations will also obstruct your progress in treatment and may result in the discontinuance of treatment.

If you are late, you will still be charged for the full scheduled appointment. If you miss an appointment or cancel less than 24 hours in advance there is a service charge of 50% of the standard fee for the scheduled service which is **NOT insurance billable**. This not a penalty, but rather your payment for the time reserved for you. It is your responsibility to contact the office and rescheduled cancelled appointments.

I understand that a 24-hour notice must be given for all cancelled appointments **to avoid the 50% cancellation fee.**

_____ _____
Signature of Client/ Parent/ Legal Guardian Date

Cost of Treatment

- Please understand that payment of your bill is considered a part of your treatment.
- As an independent mental health professional, I am committed to providing the best treatment possible for you.
- My fee schedule is what is considered usual and customary for this area.
- Standard billing fees are:
  - Initial Evaluation: $100.00
  - Attorney Evaluation: $150.00
  - 55 Minute Individual Session: $75.00
- If you do not have insurance coverage or you have an insurance that I do not bill, payment in full is required at the time of service.
- When utilizing a qualified insurance carrier, you will be required to pay all co-pays at the time of service.
- When deductibles are required, we will bill you after the insurance determination and require your payment in full within 30 days.
- The balance will be your responsibility whether your insurance company pays or not.
- Your insurance policy is a contract between you and your insurance company. You should contact your carrier as to what your benefits are along with any co-pay and/or deductible that may be required.

I understand and agree to the cost of treatment:

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

What To Expect From Treatment

- Counseling/therapy is a process in which a person seeks help, though a professional relationship with a trained counselor/therapist, to address distressing symptoms or problematic behavior patterns, as well as to promote positive personal growth.
- Clients may also experience other benefits, such as an increase in coping abilities, self-awareness, insight, spiritual discernment and relationship effectiveness.
- However, personal and relational change/growth may not come easily. It is not unusual for clients to experience a temporary increase in distress as they focus on the problematic areas of their lives. The process of therapy may also alter how you perceive yourself in relationship to others and how others perceive you. Although these changes may be positive and healthy, they have the potential to create conflict in some relationships. If you experience such distress in your relationships, you are encouraged to discuss these concerns with your therapist, so that you may receive the support you need to address issues within yourself, as well as with others.
- Client confidentiality is key to the therapeutic process. However, there are limitations to confidentiality per State and Federal law. Client confidentiality may be suspended in the event of:
  - Reasonable suspicion of suicide or other self-harm.
  - Reasonable suspicion of intended harm to other persons.
  - Reasonable suspicion of physical abuse, sexual abuse or neglect of a minor child.
  - Reasonable suspicion of physical abuse, sexual abuse or neglect of elderly or disabled persons in your care.

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

Release of Information

I hereby authorize the exchange of clinical information between my insurance company, gatekeeper, primary care physician and any other specialists to whom I would be referred for treatment under my commercial insurance, HMO coverage or Employee Assistance Program. I authorize the release of information between my mental health specialist and any court ordered requests for information. I also authorize a quality – assurance review of my file contents by a designated compliance officer of my insurance company, gatekeeper, HMO or Employee Assistance Program.

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

Consent for Treatment Form:

I acknowlege that I am voluntarily consenting to mental health asssessment and/or treatment services. I have the following rights in regards to services and may discuss these at any time with my mental health professional:

- I can discuss any intervention being suggested, as well as any questions I have concerning the course, purpose and direction of therapy.
- I have the option to explore any other possible treatments or alternatives to psychotherapy.
- I have the opportunity to discuss any possible risks, discomforts or side effects as well as any benefits that may occur in the course of psychotherapy.
- I have the right to withdraw from therapy at any time; I realize it is preferable to discuss this with my therapist first.
- My therapist will talk about the limitations of privileged communications and confidentiality. Any questions I have will be answered.
- I understand that there are no guarantees that can be promised regarding the outcome of psychotherapy. I will be iformed of what outcomes are possible.
- I agree that in the event of an emergency, contact will be made to appropriate parties on my behalf to protect others or myself.

I have read and understand the above information and will be able to address any questions pertaining to these areas as therapy progresses. On this basis, I am authorizing the necessary psychotherapeutic services.

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

Consent for Treatment of Minors:

I give permission to provide a mental health assessment and treatment services for my minor child _____.

- I am aware that under State law, if a mental health professional knows or has reason to believe that my child has been or is being physically abused, sexually abused or neglected, this information must be reported to Child Protective Services.
- All information concerning danger to a child must be reported.
- I also understand that the specific content of sessions between my child and their therapist will remain confidential and that my child has the right to request that information about his/her treatment not be shared with me.
- General reports of my child's progress may be provided to me under this agreement.

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

Acknowledgement

- I understand that I am financially responsible for the cost of services and give permission for the release of financial information to a collection agency or small claims court in the event that I fail to live up to this obligation. I further acknowledge that any costs for these financial services will be added to my bill.
- In accordance with Michigan law, the process for filing a complaint against any licensed or registered health care professional may be found at http://www.michigan.gov/lara.

_____ _____

Signature of Client/ Parent/ Legal Guardian Date

Receipt of Notice of Privacy Practices Acknowledgement Form

- I hereby acknowledge that on _____ I received the Notice of Privacy Practices from Thomas Mullens Counseling, PLLC, which sets forth the ways in which my personal health information may be used or disclosed by Thomas Mullens Counseling, PLLC and outlines my rights with respect to such informationn.

_____ _____

Signature of Client/ Parent/ Legal Guardian Date