Lisa Cree Counseling, LLC

Welcome to Lisa Cree Counseling, LLC, and thank you for entrusting me with your care. I encourage you to be an active participant in your counseling, and I welcome your feedback to assist me in directing your care. I also encourage active participation of family members and loved ones, as we find appropriate throughout the process.

Consent for Mental Health Services

I, the undersigned, agree and consent to participate in the mental health services offered and provided by Lisa Cree, LMHC, LCAC, a mental health provider, as defined in Indiana Law. I understand that I am consenting and agreeing only to those mental health services the above named provider is qualified to provide within the scope of the provider's license, certification, and training.

I understand that the treatment will consist of an assessment to identify the nature of the problem as well as counseling to help work through the issues identified. In some instances, a medication referral may be recommended by Lisa Cree, LMHC, LCAC to help control the medical aspects of the problem. I understand that I have the right to an explanation of any treatment provided to me and the associated charges, and may upon request review my treatment with my therapist.

Confidentiality

I am dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. No one may have access to your records or the information shared in your appointments without your specific permission or the permission of a legal guardian (e.g. written 'Release of Information').

The noted exceptions to this rule are as follows:

a. Provider believes the client to be a danger to him or herself or others.
b. Provider believes a child or elderly adult is being abused or neglected.
c. Parents/legal guardians of non-emancipated minors have the right to access client records as requested.
d. Records are required by court subpoena.
e. Insurance companies and other third-party payers are given information requested regarding services to clients.
f. The Executor of the Professional Will may have to access records in the event of Lisa Cree's death or incapacitation.

In the event of any of these exceptions, the provider has a moral, legal, and ethical duty to break the client's confidentiality in order to intervene appropriately.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18 years of age)

_____

Today's Date

100 SAW MILL RD., SUITE 3200
LAFAYETTE, IN 47905
765-404-1109
765-374-4164 FAX
EMAIL: THERAPY@LISACREECOUNSELING.COM

Lisa Cree Counseling, LLC

Cancellation and Payment Policy

Please call or text me at **765-404-1109** to cancel your appointment. Cancellations or changes must be made 24 hours in advance of the appointment. Cancellations made with less than a 24 hour notice will be charged a $50 fee, and missed appointments without any notification will be charged a $50 fee. Charging a fee is not something I enjoy doing, but it is a way to keep all clients accountable to the contract we have together. Missed appointments also prohibit individuals on the waiting list to be helped.

Appointments may be cancelled if you do not arrive within 15 minutes after the beginning of your scheduled appointment time.

Repeating appointments may be scheduled. This service is provided as a courtesy. Any repeated cancellations or missed appointments may result in the cancellation of subsequent appointments.

Any outstanding balance will be due prior to being seen for additional appointments. Payment for the initial assessment will be due before services are provided. Co-pays will be collected on the day of your session. I may use a third-party biller at times. This third-party biller is held to the same HIPPA regulations as I am.

If you are involved in legal proceedings that require my participation, the charges for court testimony are $200 per hour with a minimum of 4 hours. Payment is due in advance and will include preparation time, driving and waiting time. Reports for court proceedings or letters written on your behalf will be charged $25 per 15 minute increment of time I spend on your report.

Payment is due in full at the time of service.

This policy is not meant to be punitive, but it is meant to provide the most quality care through accountability and with respect to the provider, as well as to the needs of all clients scheduling.

By signing this policy, you are agreeing to the above conditions.

_____

Client Signature (Client's Parent/Guardian if under 18 years of age)

_____

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Discharge Policy

To make the best possible use of therapy it is important that you attend regularly scheduled appointments and take an active role in your care. In order to maintain a good balance of care, if you do not participate in therapy for 90 days, your file will be considered closed. Similarly, if you miss 2 or more appointments in a row, your file may be closed. You are free to contact the provider and return to therapy at any point, at the discretion of the provider.

By signing this policy, you are agreeing to the above conditions.

_____

Client Signature (Client's Parent/Guardian if under 18 years of age)

_____

Today's Date

Telehealth Therapy

I, _____, hereby consent to engage in teletherapy with Lisa Cree Counseling, LLC, if requested. Teletherapy allows counseling services to be conducted via internet technology. I understand that teletherapy involves the communication of mental health information both orally and visually. I understand that I have a right to withdraw this consent at any time. The laws that protect confidentiality also apply to teletherapy as listed in the informed consent section of the policies. I understand the risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. No recording or screenshots are allowed by either party during telehealth sessions.

By signing below, I agree to the above conditions.

_____

Client Signature (Client's Parent/Guardian if under 18 years of age)

_____

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Financial Responsibility

I accept full financial responsibility for any and all charges for counseling services provided. I give permission for my insurance to be billed as a courtesy, but I accept responsibility for any amount not covered by insurance. This includes payment for cancelled or missed appointments with less than a 24-hour notice. If I am insured by another person, I am giving permission to release only information necessary for the purposes of billing, payment, and collection.

_____ _____

Client Signature (Parent/Guardian if under 18 years of age) Today's Date

Credit Card Authorization

Visa, Mastercard, or HSA cards may be used to pay for services rendered. If you have insurance, your insurance will be billed, and the remaining balance will be charged to your card. Should there be discrepancies between a previous payment and an insurance reimbursement, the remaining balance will be charged to your card at that time. There will be notification via phone or email that this charge is being made. Any fee related to a late cancellation or no-show appointment will be charged the day of the scheduled service.

Client Name (Please Print): _____

RECURRING CHARGE AUTHORIZATION: The undersigned card member consents and permits Lisa Cree Counseling, LLC, as applicable, to charge my Credit Card Account specified below, or to any other Credit Card Account of mine that I may specify in the future, the amounts due from me for services provided to me during the applicable billing cycles. I release Lisa Cree Counseling, LLC, as applicable, from any and all claims arising from the use of this service. I understand and agree that Lisa Cree Counseling, LLC, as applicable, may continue to charge such amounts to my Credit Card Account until receiving notification from me that I have withdrawn this consent and permission at which time Lisa Cree Counseling, LLC, as applicable, shall cease charging any such amounts to my Credit Card Account.

Credit Card Information

Name as it appears on card: _____

Card Number: _____ -- _____ -- _____ -- _____

Expiration Date: _____ CVV: _____

Credit Card Billing Address:

Address: _____ City:_____

State: _____ Zip: _____

By signing this policy, you are agreeing to the above conditions.

_____

Client Signature (Client's Parent/Guardian if under 18 years of age)

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Client Rights

As a client, you have the right to:

- Select a professional counselor who meets your needs and will provide humane care in a safe setting.
- Receive specific information about your counselor's qualifications, including education, experience, national counseling certifications, and state licensure.
- Be treated without regard to religious preference, sexual orientation, or race.
- Receive an explanation of services offered, time commitments, fee scales, and billing policies prior to receipt of services.
- Understand your counselor's areas of expertise and scope of practice.
- Ask questions about confidentiality and its limits as specified in state laws and professional ethical codes. You have the right to confidentiality of your clinical records as protected by Indiana law.
- Ask questions about counseling techniques and strategies, including potential risks and benefits.
- Establish goals and evaluate progress with your counselor.
- Request additional opinions from other mental health assessment professionals if desired.
- Obtain copies of records and reports, provided that such access would not be detrimental to your physical or mental health, and would not be likely to cause you or another individual harm.
- Terminate the counseling relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's conduct with the appropriate professional counseling organization or licensure board.

My signature confirms my understanding of these Client Rights. By signing, I am also verifying that I have been offered a copy of the Privacy Practices and Client Rights that are described in the Office Policies Handouts.

_____

Client Signature (Client's Parent/Guardian if under 18 years of age)

_____

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New Client Information

Initial Assessment

The first appointment will be an initial assessment. The purpose is to gather information and to begin identifying goals to assist in guiding your treatment. You are asked to complete the initial forms prior to the appointment, and to arrive 10 minutes before the start of your initial appointment. The assessment will last approximately 1 hour.

Therapy Sessions

Individual therapy or family therapy sessions are available. Each session will last between 45-60 minutes in length. The number of sessions needed can be determined as each client's needs are evaluated. It is important to me that your experience in therapy meets your needs, so if a referral to another provider is needed, we can identify this as well.

Goals

Each client will identify his/her own goals for therapy as well as have recommendations given for a course of treatment that appears to best suit each individual. Goals for therapy may be reviewed and updated at any time.

Satisfaction

Open communication within the counseling relationship is very important. If you are dissatisfied with any services or with the direction in which treatment is going, it is encouraged that this is communicated to me. It is important to me that your experience in therapy meets your needs.

If it is determined at any time, by either the therapist or the client, that therapy is not currently meeting the client's needs, this can be discussed and a referral to another therapist may be made.

Voicemails/Emergencies

During sessions, my business phone will be on silent. Please leave a message and I will return your call as I am able; it may take a couple business days for me to return your call. If you have an emergency, including concerns of acting on suicidal thoughts, call 911 or go to the nearest emergency room. You may choose to go to Sycamore Springs or another hospital for an evaluation, if this meets your needs. They can offer more intensive services as well as inpatient options.

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