

Main Street Counseling Center - Sheri Golly, LCSW
Informed Consent, Office/Financial Policy, HIPAA and Release of Liability

Counseling is a confidential process designed to help you and/or your child address concerns, come to a greater understanding for managing issues and learn effective personal and interpersonal coping strategies. It involves a trusting relationship between you and/or your child and the therapist, who together, help accomplish therapeutic goals established as a team. Counseling involves sharing sensitive information that may be distressing at times. The outcome of therapy is most often positive, but may bring up feelings of depression and anxiety. Sheri Golly, LCSW is available to provide support throughout the counseling process to help manage those symptoms. Counseling is a confidential process but you may complete a release of information form if you would like to have Sheri Golly, LCSW discuss clinical information with physicians, school personnel, family members or other professionals.

I understand that a copy of the custody decree identifying who has legal rights regarding the minor child is required in order to provide services to children of divorced parents.

I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession. Possible exceptions to confidentiality include but are not limited to the following situations:

- abuse of child, elderly or disabled person
- potential harm or threat to self or others
- child custody cases that go before a court of law
- information subpoenaed by a court of law
- third party requests for payment

In consideration of the benefits to be derived from counseling, the receipt whereof is hereby acknowledged, I release Main Street Counseling Center, LLC and Sheri Golly, LCSW from any and all liability related to the counseling process.

The clinical records are the property of Main Street Counseling Center and Sheri Golly, LCSW and are deemed records of confidential sessions between Sheri Golly, LCSW and clients. I waive any right I may otherwise have to seek to use the clinical records as evidence in any judicial proceedings. I understand that if Sheri Golly, LCSW is subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from regular counseling rates. There is a \$1000 daily charge for court appearances as they require that Sheri Golly, LCSW cancel all client appointments for that day. A \$500 retainer is required at the time of the subpoena to hold the date and is non-refundable in the event that court is cancelled or postponed. The remaining balance must be paid in full prior to the court date. These charges are not covered by insurance and are the responsibility of the party issuing the subpoena.

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Counseling sessions last 45 minutes. For clients utilizing insurance, fees are based on contracted rates and vary between companies. As a courtesy, Sheri Golly, LCSW will verify insurance coverage and benefits but because of changes in deductibles and fees throughout the year, I understand that I am responsible for the balance of fees not covered by insurance.

For clients not utilizing insurance, the fee for the initial intake assessment is \$130 and \$90 for follow up appointments.

Telephone consultations are available to clients but are not covered by insurance. There is no charge for calls lasting less than 10 minutes. The fee for telephone consultations are \$25 per 15 minute increment.

There is a \$50 processing charge for letter and record requests. A release of information must be completed. Please allow 7 business days.

Payment is due at the time of service. All accounts are required to have a credit card on file for billing purposes including therapy, telephone consultations, letters, records requests, and late cancellations/no shows. Credit cards are uploaded into a secure electronic system at your initial appointment.

I understand there is a 24 hour notice policy to cancel appointments and that I will be charged a \$50 late cancellation fee. Reminder texts and/or emails for appointments are provided as a courtesy. Voicemail and email are available 24 hours a day/ 7 days a week.

Sheri Golly, LCSW sees clients on Wednesdays and Thursdays from 8 am- 7:30 pm, and Fridays by appointment. Appointments may be made at the end of session, by telephone, text or email. Afternoon and evening appointments are limited and are not guaranteed weekly. School and work notes are available for daytime appointments. Telephone consultations are available as needed for a fee.

If you or your child have a clinical emergency and are in danger of hurting yourself/themselves or someone else, please call 911 for immediate assistance. There is not an on-call system at this time but calls and emails are returned as quickly as possible. The National Suicide Prevention Lifeline number is 1-800-273-8255 and is available 24 hours a day.

The Notice of Privacy Practices for Main Street Counseling Center is available upon request. It is also posted online for your review. The Notice of Privacy Practices describes the types of uses and disclosures of your Protected Health Information (PHI) that will occur in your treatment, payment of your bills and the rights you have regarding your PHI. If you have questions regarding the Notice or privacy rights, contact Randy Golly, Privacy Officer at (817)886-5777 or via email at privacy@mainstcounseling.com.

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I, the undersigned, consent to treatment, office/financial policies, contact by phone and/or email and to Sheri Golly, LCSW and Main Street Counselings' Notice of Privacy Practices. My signature below indicates that I grant informed consent for Sheri Golly, LCSW and Main Street Counseling, LLC to provide therapeutic services to myself and /or minor members of my family.

I further authorize that my credit card information be stored in the electronic billing system and used for services received and for appointments cancelled without 24 hour notice.

Credit Card Number: XXXX XXXX XXXX _____ (Last 4 digits)

Card Type: Visa Master Card Discover

Name as it appears on card: _____

Expiration Date: _____

Security Code: _____

Billing Address: _____

Emergency Contact _____ **Phone:** _____

I certify that this form has been fully explained to me and I understand its contents.

Client Name: _____ Client DOB: _____

Parent/Guardian Name: _____ Relationship: _____

Client/Parent/Guardian Signature: _____ Date: _____