NELSON COUNSELING

Client Billing Release and Information

Client Information

Today's Date:	**Home Phone:**	
Legal Name:	**Cell Phone:**	
Street Address:	**Email:**	
City, State, Zip:	**D.O.B:**	**Gender:**
Emergency Contact:	**Contact's Phone:**	

Parent/Guardian Information

Please complete this section if client is under 18 years of age

Legal Name:	**Legal Name:**
D.O.B:	**D.O.B:**
Relation to Client:	**Relation to Client:**
Street Address:	**Street Address:**
City, State, Zip:	**City, State, Zip:**
Home Phone:	**Home Phone:**
Work Phone:	**Work Phone:**
Cell Phone:	**Cell Phone:**

Insurance Information/Self Pay

Name of Insured:	**Subscriber Name:**
Insurance Company:	**Employer Name:**
ID#:	**Co-Payment Amount:**
Group/Div#:	**Self Pay Self Pay Fee Amount:**

I authorize the release of any medical and/or other information necessary to process claims associated with the above named client. I authorize payment of medical benefits to Nelson Counseling, LLC for all billable services. I understand and agree that if the insurance company named above denies payment for any reason, I then become responsible for payment of all past/future sessions. I also understand that co-payments are due at the time of my appointment. I understand that I am responsible for the $85.00 fee associated with any missed appointments/appointments not canceled within 24-hours as insurance companies will not cover this.

Client Signature_____ Date _____

Therapist Signature _____ Date_____

NELSON COUNSELING

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____ **Clinician:** Peter Nelson, MLADC

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such a mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered

to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Nelson Counseling, LLC. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Signature of Client or Legal Representative Date

NELSON COUNSELING

OFFICE POLICIES AND INFORMATION

Welcome to Nelson Counseling, LLC. This document contains important information about the professional services and business policies. Although these documents are long and sometimes complex, it is important that you understand them. When you sign the acknowledgement and acceptance form, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

1. Clinician's Qualifications and Scope of Practice

I am a Licensed Clinical Mental Health Counselor and Masters Licensed Alcohol and Drug Counselor in the State of New Hampshire, as well as a Licensed Alcohol and Drug Counselor in the state of Maine. I am governed by the Code of Ethics of the National Association of Alcohol and Drug Counselors. My license and professional code of ethics are available for you to review upon request.

I received my Master's Degree in Counseling and Health Psychology from William James College in 2015. The scope of services I provide include outpatient individual counseling, couples/family counseling and group therapy.

2. Confidentiality

Under state law, communication between client and a therapist are privileged (confidential) and may not be disclosed without the specific authorization of the client except under specific, limited circumstances. Client information may be shared with others only with written permission, through a court order, or when otherwise required by law to be disclosed. Records may also be subject to audit by regulatory authorities.

Records and information pertaining to your alcohol and/or drug treatment are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, C.F.R. Part 2 and cannot be disclosed without your written consent unless otherwise provided for in the regulations. This applies to any person in the State of New Hampshire 12 years of age and older.

Within the course of treatment, a client's case may need to be reviewed with a colleague. My colleagues, of course, are legally bound to confidentiality as well. By signing the acknowledgement and acceptance form, you are acknowledging that you understand that I may discuss your case in consultation and/or supervision and do not object to my doing so.

3. Reporting Requirements

Among the exceptions to confidentiality is New Hampshire reporting laws which require therapists to report to the appropriate authorities certain types of conduct. For example, any person who suspects a child or incapacitated adult has been abused, neglected or exploited must report too state authorities.

Therapists are required to warn police or likely victims of a client's "serious threat of physical violence" to a person or property. In the event that a therapist is concerned about a client's suicidality the emergency contact listed on the clients billing form will be contacted. Under certain circumstances the police may be contacted to conduct a wellness check.

4. Couples/Families

Treatment records of couples and families sessions contain information about each person. It is the policy of Nelson Counseling, LLC to release treatment records only by joint consent. In the event of a disagreement, the records will not be released without a court order.

5. Conflicts of Interest

From time to time, actual or potential conflicts of interest may arise. In the event that I become aware of a conflict of interest in providing treatment to you, I may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be confident that any information that you shared will remain confidential.

6. Professional Boundaries

This therapist is obligated to establish and maintain appropriate professional boundaries (relationships) with present or past clients (and in some cases, client's family members). For example, a therapist should not socialize or become friends with clients and should never become sexually involved with a client. New Hampshire law states that "sexual relations with a client or former client should be considered misconduct…and shall be subject to disciplinary action". Reports of any such misconduct should be filed with the Board of Mental Health Practice, 40 Donovan Street, Concord, NH 03031, telephone number (603) 271-6762.

7. Electronic Communications

Some vendors require that I send billing and other information electronically (e.g. facsimile or e-mail). I cannot guarantee the confidentiality of such communications. If you do not consent to electronic communications, please let me know immediately, before beginning treatment so that I can determine whether and how to proceed.

8. Professional Records

Nelson Counseling, LLC maintains a file for each client or set of clients. These files include intakes, diagnosis, treatment plan, billing, consent to treatment, treatment notes, and any other written or electronic information received from or about the client. Treatment notes include the date of each session and a brief summary of key facts and issues discussed. The client(s) (or parent) is entitled to a copy of the records for a fee that covers the copying and administrative costs. If you wish to see a copy of your records, I recommend that you review them with me so that we can discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. All records for adults are maintained for a minimum of seven years following the last day of activity. For records of minors, the records are maintained for a minimum of seven years after they turn 18 years of age.

You should also be aware that I am required to have a plan in place for how my clinical records will be managed in the event of my illness, disability or death. I have made such arrangements in order to ensure that you will still have access to your records and to protect the confidentiality of your file.

9. Cost and Payment for Services

Nelson Counseling, LLC is in network with many insurance companies.

If you have an insurance plan for which I am not yet a contracted provider, you may be eligible for out of network benefits through your insurance company. Please call them directly to determine if this is a benefit under your plan.

If you do not have insurance, are waiting for your insurance to credential with Nelson Counseling LLC, or prefer to self-pay, please discuss this with option with me. Based on your financial circumstances, you may qualify for a reduced fee.

Intake/initial appointments are billed at $150.00. Additional therapy sessions are billed at $150.00 each. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will breakdown the hourly cost into 15 minute segments) for other professional services that you may require, such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or time required to perform any other service which you may request of me and is not covered by insurance.

Each insurance plan that I am contracted with reimburses at a different rate, which I have agreed to accept. The client is responsible ***only*** for their deductible and co-pays.

In an effort to help keep the cost of providing services low, co-pays are expected at the time of service. Acceptable forms of payment are cash, credit card and check. Receipt for services can be provided upon request. Should a check be returned, I require reimbursement (along with any return check fee) be paid in cash or money order before another appointment be scheduled.

If invoices have been sent and no attempt has been made to honor this financial obligation, I reserve the right to submit your invoice to a collection agency.

Nelson Counseling requires a 24 hour advanced notice for any cancellation. Failure to provide 24 hour notice will result in a missed session fee charge of $85.00. Insurance companies do not pay for missed session fee charges, this is the sole responsibility of the client. Exceptions may be made for emergencies or extenuating circumstances.

10. Managed Care

Most managed care companies limit the number of sessions which will be fully or partially reimbursed. Clients are encouraged to communicate directly with the managed care company about such limitations before starting treatment. Any concerns about the confidentiality of managed care records should also be directed to the managed care company. You should also be aware of potential risks associated with any written diagnosis being submitted to your managed care company, we can discuss private payments.

11. Court Ordered Treatment

If you are seeing me due to a court order requiring you to seek counseling, it is this practice's policy that I will receive a copy of the court order and have an opportunity to review it. Because you have been ordered by the court to obtain treatment, there are limits on confidentiality in addition to the ones described in paragraph 1 entitled Confidentiality. For example, I may be obligated to file a report with the court that ordered you to seek treatment or with someone else.

12. Limits of Availability

This therapist will make every effort to return your phone call promptly, however due to the nature of this practice, it may take up to 24 hours to return phone calls. Should you need a more immediate response, please reach out via e-mail. However if you are experiencing an emergency, such as thinking of harming yourself or others, you should not wait for a return phone call or e-mail from this therapist and should instead proceed to your local emergency room or call 911.

13. Limits of Services

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have significant benefits. However there is no guarantee what you will experience. Psychotherapy requires an active effort on your part. In order to be most successful, you will need to work on things we discuss outside of sessions.

Nelson Counseling LLC does not provide medication evaluations or medications management. If you are in need of a medication evaluation, you will need to arrange for this through a psychiatrist, private physician or ARNP.

Please be advised my role is to provide therapy services. I will not assess fitness for custody, serve as an advocate on other issues or act as an expert witness. Please be aware that if I am subpoenaed to court, you will be charged a fee of $150.00 per hour for any time spent in the court plus travel time.

14. Concerns or Complaints

Nelson Counseling LLC is committed to providing high quality services. If you have any complaints about treatment that you have received or about billing, please do not hesitate to address them with me.

ACKNOWLEDGEMENT AND ACCEPTANCE
OFFICE POLICIES AND INFORMATION

You acknowledge that you have received and reviewed Nelson Counseling LLC Office Policies in its entirety. Your signature below indicated your acceptance of and agreement to all of its terms. By signing this document, you agree to begin services with Nelson Counseling LLC.

By signing this document you also agree to be financially responsible for your account which includes but is not limited to copayments, phone calls, letter writing, travel time, attendance at meetings, court appearances, and services that your insurance company does not cover.

Nelson Counseling LLC keeps credit card numbers on file for each client in case there is an outstanding account balance which has not been paid. In the event your credit card is used to pay off an outstanding account, you will be charged the full amount that remains unpaid.

I certify that I am the cardholder and my signature below authorizes use of this card. I understand that this form authorizes my provider to charge this card(s) for all unpaid service fees, across multiple dates of service.

CARD #1 ☐ Mastercard ☐ Visa ☐ Discover

IS THIS A HEALTH INS. SPENDING CARD? ☐ Y ☐ N

Name on card: _____

Credit card number: _____

Three digit card code (located on back of card): _____

Exp. Date: _____ Zip Code: _____

CARD #2 ☐ Mastercard ☐ Visa ☐ Discover

IS THIS A HEALTH INS. SPENDING CARD? ☐ Y ☐ N

Name on card: _____

Credit card number: _____

Three digit card code (located on back of card): _____

Exp. Date: _____ Zip Code: _____

Signature **Printed Name**

_____ _____

_____ _____

_____ _____

SUBMIT