INNOVATIVE COUNSELING SERVICES
228 Broadway St. Hanover, PA 17332
PH: 888-821-2935
jeanpollack@emdrcoach.com

CLIENT INFORMATION

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

_____

HOME PHONE:_____ WORK PHONE:_____

CELL PHONE:_____ EMAIL ADDRESS:_____

How would you like to be contacted? (circle home phone, work phone, cell phone, email)

Is it ok to leave you a message via phone or email? YES / NO

INSURANCE INFORMATION

Do you want us to prepare your insurance claim forms? YES / NO

INSURANCE COMPANY:_____

SUBSCRIBER'S NAME:_____

CLIENT AGREEMENT

This document (The Agreement) contains important information about my professional services and business policies. So that misunderstandings may be avoided, it is very important that you read my policies carefully and ask for clarification when needed. After reading this carefully, please sign and date this form. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have incurred.

PAYMENT OF CO-PAYMENTS AND OUTSTANDING PATIENT BALANCES WILL BE COLLECTED AT THE TIME OF CHECK-IN. PLEASE BE PREPARED AND HAVE YOUR PAYMENT METHOD READY.

WHAT TO EXPECT FROM PSYCHOTHERAPY:

I normally conduct an initial evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once psychotherapy has begun, I will usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Later in the treatment process, the sessions are spaced out to every other week and then monthly.

There are many different methods I may use to help you address and cope with problems (e.g., exploring your feelings and needs, teaching coping strategies, improving your communication skills). Our initial sessions will involve an evaluation of your needs. By the end of the evaluation, I

will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You can monitor the effectiveness of your treatment with various assessment tools that I will provide you during our sessions. The scores will show if you are improving. In addition, I routinely help clients identify the approaches we're taking in counseling, so that these strategies can be implemented individually in the future.

How to Promote a Partnership with Your Therapist:

It's important to feel that your therapist respects and understands you. Sharing feedback with your therapist enhances the teamwork and hence, often makes therapy more effective. There may be times when you feel stuck and convinced that you are not making progress. You may get annoyed with something your therapist said or convinced that she or he does not really understand you. It can be extremely helpful to discuss these feelings with your therapist, even though it is not always easy. You may be uncomfortable with conflict; however, if you do not tell your therapist how you feel, the treatment may be compromised.

Information About Payment:

I accept checks, payable to Jean Pollack, Innovative Counseling Services, Inc.

Telephone Consultations per quarter hour - $45.00
Form Preparation, per quarter hour increments - $45.00
Preparation or Attendance in Legal Proceedings, per hour - $125.00
Missed Appointment/Late Cancellation – Copay or $25.00 fee
Other services, not listed above – Negotiable fee

Please note: Payment for services is the patient's responsibility and due at the time of service. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.
In addition, during the course of therapy it may become necessary to increase fees to compensate increased overhead costs and inflation. Fees will be periodically reviewed and will not be increased more than one time annually.

Information Regarding Insurance Coverage:

Please be advised that I am **'in network'** with some insurance companies and am an **'out-of-network'** provider with insurance companies. I will provide you with the completed forms for you to file when out-of-network; however, you (not your insurance company) are responsible for full payment of my fees.
It is very important that you find out exactly what mental health services your insurance policy covers. If you have a secondary health insurance company, you will need to find out that coverage and the interactions with the first coverage as well. Thus, it is the patient's responsibility to verify the details of your mental health coverage with your insurance company(ies) and to determine if an authorization is required.
Other information you may want to obtain from your insurance company might be: *deductible amounts, reimbursement amounts*, information regarding *pre-authorization or authorization requirements, number of visits allowed per benefit year, the dates of the benefit year, if a referral from your primary care physician or a psychiatrist is required, yearly and lifetime maximum reimbursement amounts, etc.* When consulting with your insurance company, advise them that you are requesting *out-of-network mental health services.*

Also, please be advised that your health care plan may not cover many useful and appropriate services, such as sessions conducted via the telephone, family therapy sessions, case-coordination or form preparation. It is your responsibility to advise me if you have a change of address, phone number(s), insurance coverage, and/or place of employment so that we can update our file for account accuracy. If your insurance company denies covered charges or changes coverage, the fees of this office continue to be the responsibility of the patient. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you, including a clinical diagnosis. Sometimes I am required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medication information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.
Please note that you always have the right to pay for my services without seeking insurance reimbursement in order to avoid the problems described above (unless prohibited by contract).

Phone Calls and Emergency Contact:

You can contact me at (888) 821-2935. If I am unavailable, please leave a message on my voice mail and I will make every effort to return your call within 24 hours of your call (during business hours, Monday through Friday).
For psychological emergencies, call 911 or go to the nearest hospital and ask for the psychiatrist on call.

Accessing Your Records:

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other personal is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents.

A SEPARATE CONSENT TO RELEASE MEDICAL RECORDS FORM must be executed by the patient before we can release these records. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

It is important to be aware that email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. A non-

encrypted email, such as this, is even more vulnerable to unauthorized access. Please notify Dr. Pollack if you decide to avoid or limit, in any way, the use of email. Unless I hear from you otherwise, I will continue to communicate with you via email when necessary or appropriate. Please do not use email for emergencies. While I check my phone messages frequently during the day when I am in town, I do not always check my emails daily.

I agree to be contacted by email or by text and I understand that privacy and confidentiality with such communication may be compromised.

By signing this form you agree to receive information/newsletter from Innovative Counseling Services, Inc.

_____ Date_____

Please read all information carefully and complete necessary information.

***Your signature below indicates that you have read this agreement and agree to its terms.**

_____

Patient's Name

_____ _____

Signature **Date**

_____

Relationship to Patient