LIGHTHOUSE COUNSELING SERVICES LLC
LIGHT FOR SIGNIFICANT LIVING AND RESTORING RELATIONSHIPS

Consent and Agreement for Treatment

Consent to Collect, Create, Use, Maintain, and Disclose Your Health Information

(A separate form must be completed for **each adult participating** in treatment)

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. This information may include your health records, health history, symptoms, examination and test results, diagnosis, treatment, treatment plans, and billing and health insurance information. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business (such as supervision) or required government functions (such as reporting abuse).
The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the Privacy Notice before you sign this Consent form.

Informed Consent
Informed Consent is an interactive process between client and therapist involving your right to have the following information explained to you:

- your condition or diagnosis,
- the nature and purpose of treatment,
- the likelihood of success,
- the risks and potential consequences of treatment, including refusing treatment, and the consequences of doing so,
- the alternatives to treatment, including refusing treatment, and the potential consequences of doing so,
- the right to include or exclude your family or significant other/s in treatment, to the extent permitted by the law.

By signing this form, I am indicating:

- I have read, understand, and agree to the terms of the **Consent and Agreement for Treatment** as outlined above, except as otherwise noted in writing.
- I have been given the opportunity to review and have accessed a copy (http://www.lighthousecounselingmft.com/NoticeofPrivacyPractices.en.html) of the **Notice of Privacy Practices** of Lighthouse Counseling Services. Lighthouse Counseling Services reserves the right to change its notice and practices at any time, if it sends a copy of the revised noticed to the email address that I have provided.
- I understand that the information shared during counseling sessions is regarded as confidential and that there are limits to confidentiality spelled out in the **Notice of Privacy Practices**. Of specific note, reports or suspicion of abuse or neglect of minors and the elderly, or reports of intention to harm myself or others requires Lighthouse Counseling Services, by law, to report to the proper authorities.
- As a consenting adult, I agree to permit the staff at Lighthouse Counseling Services to provide me with treatment.
- I understand that I have the right to request restrictions, in writing, on the use or disclosure of my information. I understand that Lighthouse Counseling Services is not required to agree to those restrictions, but if it does, it must honor the restriction unless I revoke the request or it notifies me that it is no longer going to honor the request.
- I understand that I have the right to discontinue treatment at any time.

Note: If you do not sign this consent from, we will not be able to treat you, unless we are required to do so by law. After you have signed this consent, you have the right to revoke it, in writing, and we will comply with your wishes from that time forward. Revoking consent does not affect actions already taken by Lighthouse Counseling Services.

_____ _____
Printed Name of Client (or parent of minor client) Date of Birth

_____ _____
Signature of Client (or parent of minor client) Date

_____ _____
Witness Signature Date

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Client Commitment

(Effective October 2016)

- The fee for the initial assessment session is $175 per hour.
- The fee for subsequent sessions is $140 per hour.

(See Fees and Payments page to view our full fee schedule)

Please mark the pre-approved commitment option below:

1. _____ I agree to pay the full fee listed above out of pocket.

2. _____ Lighthouse Counseling Services will bill my insurance at the full fee listed above. I have provided my insurance information to Lighthouse Counseling Services in advance of the first visit. When my quoted coverage has been determined, I agree to pay my co-payment at each session.

3. _____ I do not have insurance coverage and I cannot afford to pay the full fee listed above. I have submitted the completed Fee Reduction Application form. (http://www.lighthousecounselingmft.com/FeeReductionApplication.en.html)

   The agreed upon amount is: $_____

As a client of Lighthouse Counseling Services, I am aware that my responsibilities include:

- An honest assessment of my ability to pay.
- Paying my fees/copayments and any balances accrued promptly.
- Being charged and being responsible to pay a $75 when…
  - I fail to give a 24 hour notice when canceling an appointment.
  - I do not show up for a scheduled appointment.
  - I understand that my insurance, if any, will not cover the cost of this fee.

If Lighthouse Counseling Services will file insurance claims on my behalf, I am aware that my additional responsibilities include:

- Complying with any/all requests for documentation from my insurance carrier in a timely manner.
- Taking financial responsibility for the full fee for any/all sessions not paid by my insurance due to my failure to provide such documentation.
- Understanding that any quote of insurance coverage provided by my insurance carrier, and obtained on my behalf by Lighthouse Counseling Services, is an estimate of coverage, and that Lighthouse Counseling Services is not responsible for any errors in the information provided.
- Understanding that I am responsible for all fees not covered by my insurance

I understand Lighthouse Counseling Services reserves the right to charge the credit card I have on file the remaining balance of my account, if my account is overdue by 90 days. If my credit card is declined I understand Lighthouse Counseling Services reserves the right to pursue collection of delinquent accounts. I understand that in the event my account is sent to collections, I will be responsible for all collection costs and legal fees.

Print Name: _____

Signature: _____ Date: _____

Client Information

The primary client's information entered on this form will be used to submit any insurance claims. Separate **Consent and Agreement for Treatment** forms will be required for each individual participating in counseling. Separate **Client Information** forms may be required if clients listed here have separate therapists or participate in multiple counseling processes.

Primary Client Information:

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary # _____ Circle: Home Cell Work

Secondary # _____ Circle: Home Cell Work

Email: _____

Date of Birth: _____ Male _____ Female _____

Marital Status: _____ Attending counseling with spouse? Y/N

Name of Spouse: _____

Employer or School: _____

Employment Status: _____

Billing Information (If financially responsible party is other than the client):

Same as the above: _____

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary # _____ Circle: Home Cell Work

Secondary # _____ Circle: Home Cell Work

Email: _____ Male _____ Female _____

Date of Birth: _____

Client Insurance Information

This form **ONLY** needs to completed if:

- One or more of your insurance cards are unavailable to be copied for our records.
- If the "Primary Insured" on the insurance policy is different from the "Primary Client" information provided on the **Client Information** form.

Primary Insured Information:

Client Relationship to Insured: Self _____ Spouse _____ Child/Other _____

If client relationship to insured is "Self" and you have provided front & back copies of insurance cards, and completed the Client Information form, you do not need to complete this form!

Insured's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary # _____ Circle: Home Cell Work

Secondary # _____ Circle: Home Cell Work

Email: _____

Date of Birth: _____ Male _____ Female _____

Insurance Company Information:

If you have provided copies of both sides of insurance cards you do not need to complete this section of this form.

Please Indicate one of the following: Primary Insurance: _____ Secondary Insurance: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____

Policy Number: _____ Group Number: _____

If you have coverage on multiple insurance policies, please print a second copy of this page and indicate "Secondary Insurance" above.

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Credit Card on File

Lighthouse Counseling Services requires that an active credit card be kept on file to charge for sessions missed or canceled with less than 24 hours notice, and for accounts that are over 90 days past due. Please complete this form for our records.

I, _____, hereby authorize Lighthouse Counseling Services, LLC to keep the following credit card information on file to be used in ways spelled out below.

Credit Card Information:

Card Type: Visa _____ Mastercard _____ American Express _____ Discover _____

Card Number: _____

Expiration Date: _____ Security Code #: _____

Name on Card: _____

Billing Adress: _____

City: _____ State: _____ Zip: _____

Cardholder's Signature: _____

In the event that my account becomes 90 days past due, I hereby authorize Lighthouse Counseling Services to charge the above referenced credit card for the balance amount that is 90 days past due. I understand that if the above referenced credit card is declined, Lighthouse Counseling Services reserves the right to pursue collection of delinquent accounts. I understand that in the event my account is sent to collections, I will be responsible for all collection costs and legal fees.

Signature: _____ Date: _____

In the event that I cancel my scheduled session with less than 24 hours notice, or fail to show up for my scheduled session, Lighthouse Counseling Services reserves the right to charge the above referenced credit card the pre-determined fee established by Lighthouse Counseling Services of $75. I understand that my insurance, if any, does not cover the cost of this fee.

Signature: _____ Date: _____