Correspondence Address

523 ½ Court St.
Williamsburg, IA 52361
www.midwestcounselingllc.com

(319) 668-1217 (Intakes and Billing)
(319) 668-1220 (Fax)

Dear New Client:

Welcome and thank you for choosing us to help you on your healing journey.

Your work is just beginning. Filling out the enclosed forms before coming to your first appointment allows your therapist to use your time wisely. Please either bring all the forms with you to your first session.

1. **Billing Insurance Registration**: We need this information from you for billing and audits. Please bring your insurance card in with you so we can make a copy for our records.
2. **Therapy Service Agreement**: Two copies. One is yours to keep. Please read through this carefully. If you have any questions, please feel free to ask your therapist, they can help you understand the contents of the agreement.
3. Copies of our HIPPA Privacy notice is available upon request from our HIPPA privacy officer. Please contact our office to request.

We are in-network providers for most major insurance companies. As a courtesy to you, we work directly with your insurance and will make every effort possible to bill your insurance company.

In compliance with health insurance contracts, The Ardent Center requires that all copayments are collected for payment at the time of service and that all coinsurance and deductible amounts are collected immediately following insurance claim processing. Please make sure that you are prepared to make payment for your copayment via (check/money order or credit card via a reoccurring authorization form attached) We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.

Please be on time for your appointment. This is ***your*** time.

Sincerely,

Midwest Counseling

Midwest Counseling

523 ½ Court St
Williamsburg, IA 52361
Intake: 319-668-1217

A. CLIENT INFORMATION: **Code:** _____
(please leave blank -therapist use only)

Today's Date: _____ **Referral Source:** _____

Client Name: _____
Last First Middle I. Preferred Name

Address: _____
Street/PO Box City State Zip Code

Client Date of Birth (DOB): _____ **Age:** _____ **Employer:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

To contact you by phone, please check which of the following would be acceptable:

___ Call home	___Call work	___ Call cell phone
___ Leave message on machine	___ Leave message on v-mail	___ Leave message on v-mail
___ Leave message w/person	___ Leave message w/person	___ Leave message w/person

B. INSURANCE INFORMATION: If you are covered by one insurance policy, complete part (1) below. If you are covered by two insurance policies, complete parts (1) and (2) below.

(1) Name of PRIMARY Insurance Company: _____

Subscriber Name: _____ **DOB:** _____ **Employer:** _____

Policy/ID Number: _____ ***(on insurance card)*** **Group Number:** _____ ***(on insurance card)***

Subscriber Address: (*if subscriber lives at different address from client or parent responsible for billing, please complete)*

_____
Street City State Zip Code

(2) Iowa Wellness Plan: _____

Subscriber Name: _____ **DOB:** _____

ID Number: _____ ***(on card)***

Subscriber Address: (*if subscriber lives at a different address from client or parent responsible for billing, please complete)*

_____
Street City State Zip Code

Please complete other side

C. SPOUSE/SIGNIFICANT OTHER:

Name: _____ **Phone(s):** _____

D. EMERGENCY INFORMATION:

In the event of an emergency, who should be contacted? _____

Relationship to client: _____ **Phone(s):** _____

Primary Physician: _____ **Psychiatrist:** _____
Name **Name *(if applicable)***

E. IF CLIENT IS UNDER AGE 18 OR IN COLLEGE:

Mother's Name: _____ **Phone(s):** _____
Father's Name: _____ **Phone(s):** _____

Person responsible to pay for services: _____ **Relationship to child:** _____

Responsible Person's Address: (*if responsible person lives at a different address from the client, please complete)*

_____
Street City State Zip Code

GENERAL CONSENT *(Please select Option A or Option B)*

___ **A. By signing this form, I am stating that the information I have provided is accurate. I also authorize my therapist and her staff to release protected health information from my clinical record to any of the following entities as applicable for the purposes of certification of psychological services and/or billing for payment of those services: (1) EAP program, (2) a county funding organization, (3) my health insurance company, and/or its (4) designated managed care company. I understand that this authorization continues indefinitely unless I revoke it in writing. However, if I revoke this authorization, I understand that any of the above entities retains the right to information in my clinical record prior to the revocation date.**

___ **B. By signing this form, I am stating that the information I have provided is accurate. I *do not wish* to have an insurance company or other third party pay for the psychological services provided to me or to the person designated as the "client" on the front of this form. I agree to be responsible for payment of all services provided.**

_____ _____
Client/Parent/Legal Guardian **Date**

CLIENT COUNSELING AND THERAPY SERVICE AGREEMENT

Midwest Counseling

523 ½ Court Street Williamsburg, IA 52361 and 821 5thAve. St STE 208 Grinnell, IA 50112

(319) 668-1217

Please read and sign two copies of this agreement. Keep one copy for your records.

Midwest Counseling is a business facility where a number of mental health professionals practice. Some therapists are independent practitioners and others are employees working under the supervision of an independent practitioner. Your contract for services is with Midwest Counseling and all therapists who practice at Midwest Counseling. Your therapy will be handled by your therapist, although your treatment may be discussed with other therapists at Midwest Counseling. If for any reason you wish to change to a different therapist practicing at Midwest Counseling, please contact Midwest Counseling with this request.

Rights and Risks: Please feel free to ask questions about any aspect of the counseling process. · If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report. ·You need to be willing to discuss what troubles you and be open to change. · As a result of counseling, you may remember unpleasant events, arouse intense emotions, and/or alter close relationships.

Confidentiality: Confidential Information shared will be held in confidence in compliance with applicable state and federal law. "Confidential Information" includes any recordings or transcripts of therapy sessions, therapist notes, medical reports or therapy progress reports. · Information will not be released without your written consent, except for professional consultation if needed or if disclosure is required by law. · Your therapist may be required by law to disclose information pertaining to suspected child abuse; inability to care for one's basic needs for food, clothing or shelter; and threatened harm to oneself or others. · Should your therapy be involved or be the subject of court proceedings or litigation, your counseling records may be subject to subpoena. · It is understood that information regarding treatment and diagnosis may be provided to an insurance company. · You may want to discuss further limits or exceptions of confidentiality. · Information regarding you counseling and therapy will be used internally by Midwest Counseling for the purposes of coordination and supervision, and will not be released to any third party without your express written release.

Client Agrees to: ☐ Allow **the therapist to be assisted by a co-therapist if either or both deems it appropriate.**

> **Note on Privacy**: I understand that the counseling sessions in which I participate with a co-therapist are for the purpose of improving my care. I understand that confidential information will be shared between my therapists and any co-therapists involved and I hereby authorize such disclosure.

Appointments: All office visits are by appointment with your therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. · Late cancellation (less than 24 hours before) and/or no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get the voice mail. If your appointment is canceled or missed, contact your therapist for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees:

The client portion (co-pay or full amount) of fees is expected at the time of service. · Your health insurance may help you recover some of your counseling costs. Please verify with your insurance company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled prior to your first visit.

Uninsured clients are expected to pay their fees as services are rendered. If required, Ardent will fill out and submit forms to your insurance company. Otherwise Ardent will provide you with whatever forms and assistance available to help you receive the benefits to which you are entitled. This office will not accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. **Clients are responsible for payment (and insurance claims) on their accounts.**

Failure to pay your part may jeopardize your benefits. Copays are not negotiable. Clients paying on a cash basis and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged. Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable. Accounts become delinquent after thirty (30) days. Delinquent accounts may be turned over for collection.

If for any reason your insurance company does not make a complete payment to Midwest Counseling within **30** days of my office visit, I understand that I will be sent a bill explaining my amount due. If I do not submit payment to The Midwest Counseling within the following **10** calendar days, **I hereby authorize you to debit my credit card (on-file) for the total amount due.**

In the event that the Insurance Company denies payment or applies the visit charge to my deductible, I understand that I am responsible for the amount billed by The Midwest Counseling. As we are a fee for service the balance of your bill is due in full immediately, **I hereby authorize you to debit my credit card for the total amount due**.

I understand that should my credit card on file not be approved I am still fully responsible and understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be charged a 1.5% service charge monthly on the remaining balance.

In the event that I cancel an appointment within 24-hours or fail to attend a scheduled appointment, I hereby authorize Midwest Counseling to charge to my credit card the amount of the cancellation or missed appointment fee, in the amount of $75 for a scheduled 50-minute session, or $75 for a scheduled 75-minute session. I authorize my credit card to be charged for patient balances pursuant to the above signed agreement.

Returned Checks: If I write a check that I have written to The Midwest Counseling is returned, I hereby authorize you to debit my credit card for the total amount due plus and administrative for of $25.00. Thereafter, the entire account balance will be paid in cash or a money order.

Phone calls over five (5) minutes will be billed in 15 minute increments, at $30 per 15 minutes. This will not be processed by insurance (if the insurance company does not cover phone sessions) and will be owed from the client to Midwest Counseling.

I will discuss any change in my financial situation with my therapist. I have read, understand and agree to the above policies. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if I desired. I hereby authorize Midwest Counseling and my therapist to release to my insurance company any information acquired in the course of my therapy (if client is a minor, by signing this agreement I certify that I am the parent or guardian of the minor child and authorize this release). I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by or on account of this client and hereby assign Midwest Counseling and all Insurance benefits due to me to the full extent of my financial obligation to Midwest Counseling. I have read and/or received a copy of Midwest Counseling Privacy Policy. If conjoint (couple or family) all adults need to sign this contract because of confidentiality and our rights, even though one person is the identified patient.

Insurance Code	Description	Unit	Price
90791	Initial Intake Interview/Assessment	75-90 minutes	$200.00
90837	Counseling Sessions	60 minutes	$150.00
90834	Counseling sessions	45 minutes	$120.00
Not Billable to Insurance	Cancelled w/in 24-hours or missed	Any	$75.00
Not Billable to Insurance	Hearing preparation/documentation	60 minutes	$175.00
Not Billable to Insurance	Fees, Phone calls, Letters, & Reports	1-15 minutes	$25.00
Not Billable to Insurance	Phone/Video Therapy	15 minutes	$30.00
Not Billable to Insurance	Court Appearances	45-50 minutes	$250.00

I acknowledge I have received, read and understand The Midwest Counseling and Therapy Service Agreement. By signing below I agree to the terms of the agreement:

Client Signature:_____ Date: _____

Client Signature:_____ Date: _____

Please Initial One

Recurring Authorization:	
Cancel Authorization:	

Credit Card/ACH Payment Authorization Form

Name of Person authorizing payment:											
Name of business (if Applicable and hereafter "Accountholder")											
Address:											
City		State:		Zip:							

Credit Card type (please check one)	MC			VISA		Discover				AMEX			
Credit Card Number: MasterCard or Visa or Discover			MasterCard, Visa or Discover Card here (no spaces or hyphen)												
Expiration Date (MM/YY)			/			VID CODE (3-digit on Back)									
Credit Card Number: (American Express):			American Express here (no spaces or hyphen)												
Expiration Date (MM/YY)			/			VID CODE (4-digit on Front)									

Checking (Check one)		Savings (Check one)		Please Attach a Voided Check	
Routing Number:				Bank Transit/ABA No.	
Financial Institution Name				City ,State, Zip Code	

By completing and executing this form, the cardholder acknowledges and agrees that Rodasi LLC. dba "Midwest Counseling" (hereafter "Company) is authorized as of the authorization date set forth below and subject to the terms and conditions set forth below, to charge the credit card, debit card, chard card, electronic check draft (ACH) or other payment card (each referred to herein as "Credit Card" or Check), specified above for the amounts billed to the accountholder or the card holder specified above for service rendered.

Company will sent the accountholder or cardholder an invoice for service rendered. Company will charge the above credit card or ACH for the amount specified in the invoice on or around the date of the invoice. The account holder/credit card holder should ensure such charge will not cause the credit card account or ACH draft to exceed any established credit /bank limits or available balances as on the date of charge/draft/ There will be a $25.00 penalty for any rejected charge pursuant to this authorization. Cardholder acknowledges that they will continue to be liable for any such rejected or any unpaid charges including all penalties. Cardholder further authorizes Company to initiate a chard or credit as necessary to correct any prior overpayment or underpayment of any invoice or any other charge or credit effected under this or prior authorization (s) Company and cardholder further acknowledge that if this payment authorization is for a recurring charge/ draft, then Company will inform cardholder of any variances in the recurring amount. Each charge will appear as a payment on the next invoice sent to accountholder/cardholder after the charge date. All charges and ACH debits will appear as Rodasi LLC and or Midwest Counseling.

To Update/Cancel the above credit card information, please execute this form and check "Update information" or "Cancel authorization and fax back to number provided below. This authorization shall remain in effect until Rodasi LLC, dba Midwest Counseling, receives a new form requesting an update or cancellation, and Midwest Counseling has had sufficient time to clear any arrears and act on the authorization. Cardholder will continue to be liable for any invoices due and pending as of such termination. Cardholder is responsible for informing Company of and changes in the above information.

If you have any question on billing or credit card/ACH charges please contact our correspondence address, Midwest Counseling 684 Barrington rd. Suite 112 Streamwood, IL 60107

Signature of Cardholder/Accountholder:
Authorization Date: