



## Client Information

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
(Full Legal name: First Middle Last) (Month Day Year)

If Minor, Name of Parent(s)/Guardian: \_\_\_\_\_

Optional:

Preferred Name and/or Pronouns: \_\_\_\_\_

**Address:** \_\_\_\_\_  
(Street and Number) (City,State,Zip)

**Phone:** \_\_\_\_\_ May we leave a message?  Yes  No  
May we text you?  Yes  No  
**Email:** \_\_\_\_\_ May we email you?  Yes  No

*\*Please be aware that email might not be confidential.*

**Client Occupation and Employer:** \_\_\_\_\_  Student

**Client Marital Status:**  Single  Partnered  Married  Separated  Divorced  Widowed

\_\_\_\_\_  
**Partner's Full Name**

\_\_\_\_\_  
**Date of Birth**

### Emergency Contact:

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_  Same as client  
(Street and Number) (City,State,Zip)

**Phone:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

How did you hear about us?



**Primary Health Insurance & Payer Information**

Subscriber Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Relationship to client:  Self  Parent/Guardian  Spouse  Other

Insurance Company: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Deductible Remaining: \_\_\_\_\_ Co-Payment: \_\_\_\_\_

Subscriber's address:  Same as client

\_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip) Phone: \_\_\_\_\_

**Secondary Insurance or Other Payer\*:**

Subscriber/\*Organization Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Relationship to client:  Self  Parent/Guardian  Spouse  Other

Member ID#: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

\*Company Name: \_\_\_\_\_

Deductible Remaining: \_\_\_\_\_ Co-Payment: \_\_\_\_\_

\*Subscriber/Organization address (if different from above):

\_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip) Phone: \_\_\_\_\_

\*Email: \_\_\_\_\_



## Patient Signature Record

Client Name: \_\_\_\_\_ Therapist Name: \_\_\_\_\_

**After Reading The Client Contract, Please Answer The Following Statements.  
Place your initials after each statement.**

**Acknowledgement of HIPAA:** Your signature below indicates that you have read the HIPAA notice of confidentiality agreement and agree to its terms, and also serves as an acknowledgement that you have been offered and declined or offered and furnished with the HIPAA notice of privacy practices.  (initial)

**Therapeutic services contract:**  (initial)

**Select one of the following:**

As billed to insurance

Paying by Cash/Credit ⇒ If so, our agreed upon session fee is: \$ \_\_\_\_\_ \*

*\*ask your therapist if you aren't sure*

**Insurance, billing and consent for services:**  (initial)

**Teletherapy Informed Consent:** I hereby consent to engage in online counseling services with \_\_\_\_\_ (therapist) through Alliance Counseling Group.  (initial)

**I have read and agreed to the terms and conditions of this document. I acknowledge that I am the client or the legal representative of the client, and I agree that my signature is a legally binding agreement.**

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Parent/Guardian Signature (if client is under 18 years)*



## **Acknowledgment of Review of the HIPAA Notice of Confidentiality**

**BACKGROUND:** The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. I am required by law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice.

The *HIPAA Notice of Privacy Practices* and the *Patient's Rights and Responsibilities* documents can be printed for you upon your request and is also posted and available for download at [www.alliancecounselinggroup.com/forms/](http://www.alliancecounselinggroup.com/forms/)

**YOUR SIGNATURE ON THE PATIENT SIGNATURE RECORD INDICATES THAT YOU HAVE READ THE HIPAA NOTICE OF CONFIDENTIALITY AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED AND DECLINED OR OFFERED AND FURNISHED WITH THE HIPAA NOTICE OF PRIVACY PRACTICES.**

## **THERAPEUTIC SERVICES CONTRACT**

This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES** Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. It is my aim, to provide psychotherapy that leads to better relationships, solutions to specific problems, and better emotional health.

**PROFESSIONAL DISCLOSURE** Please refer to <http://www.alliancecounselinggroup.com/team/> for a complete listing of my educational background, professional credentials, and scope of practice.

**PROFESSIONAL FEES** The initial therapeutic session will be billed at \$215 for PhDs /



Psychologists and \$170 for master level providers. Subsequent therapeutic sessions will be billed at \$200 for PhDs and Psychologists and \$150 for master level providers. Session fees are subject to the contracted rates with insurance providers. In addition to charging for therapy sessions, I charge the full hourly rate for other professional services I provide (including, but not limited to, report writing, phone calls, transportation time, and so forth), whether these services are provided at your request, at the request of your lawyer, or at the request of any other individual who is acting on your behalf.

## **INSURANCE, BILLING AND CONSENT FOR SERVICES**

**BILLING AND PAYMENTS** You will be expected to pay for each session at the time of service. Cash, checks, and credit cards are accepted. Payment methods include check, cash, or the following charge cards: Visa, Mastercard, American Express, and Discover. A 3% convenience fee will be added to all credit and debit card transactions. Most Health Savings Account (HSA) and Flexible Spending Account (FSA) cards are accepted free of processing fee. A receipt is available upon request. Checks can be written to the Burke Group.

**INSURANCE** I accept a variety of insurances. I recommend calling your insurance provider before your appointment in order to be aware of your insurance coverage (including your deductible and copays). I use a third party biller for insurance billing and the claims will be processed through the Burke Group Counseling and Consulting LLC. *Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.*

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases you, the client, are responsible for payment of these services. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

**USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS** We may use or disclose information in your records for treatment, payment, and health care operations purposes with your consent. Personal health information (PHI) refers to information in a client's record that could identify that client. *Use* of this information refers only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *Disclosure* of information refers to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be



responsible for the client.

In providing for your treatment, we may use or disclose information in your record to help you obtain health care services from another provider, or to assist me in providing for your care through consultation with other treatment providers, outside clinical supervisors, and/or supervisors within the Alliance Counseling Group office. For example, we might consult with another health care provider, such as your child's pediatrician or another therapist.

In order to obtain *payment* for services, we may use or disclose information from your record, with your consent. For example, we may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care.

We also may use or disclose information from your record to allow *health care operations* (e.g., quality assessment and improvement activities, business---related matters such as audits and administrative services, and case management and care coordination).

**MISSED APPOINTMENTS** Once an appointment hour is scheduled, you will be expected to pay a full session fee unless you provide 24-hour advance notice of cancellation. I cannot offer exceptions to this policy.

**CONTACTING ME** I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available and alternative numbers to call. If you are unable to reach me and feel that you cannot wait for me to return your call, please contact **911** (24 hours/day) or proceed to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**EMAIL** If agreeing above to being contacted by email, please be aware of the following: 1) The use of email is limited to *setting up or canceling appointments, for sending appointment reminders, and for sharing resources or homework assignments*. 2) Due to security, details of your treatment cannot be discussed via email. 3) Email may also not be used as a means of providing services. 4) You also agree to not use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as we cannot guarantee rapid response via email. 5) By consenting to email, you are aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold Alliance Counseling Group or your therapist responsible for any breach of confidentiality that results from the use of the email address listed above.

**MINORS** If you are under eighteen years of age, please be aware that the law may provide your



parents the right to examine your treatment records. It is my policy to request that your parents agree to waive access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss

**CONFIDENTIALITY** In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- If I believe that a child, psychologically or physically compromised adult, or an elderly person is being abused, I must file a report with the appropriate state agency.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If I believe that a client is threatening serious bodily harm to another person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I have read the information in this document and agree to abide by its terms during our professional relationship.

**QUESTIONS AND COMPLAINTS** If you have questions about our privacy practices or are concerned your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your questions or concerns to:

Dan Zomerlei, PhD, LMFT-Clinical Director  
Alliance Counseling Group  
PO Box 283  
Grandville, MI 49418

You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You will not be penalized or otherwise retaliated against for filing a complaint.



## **TELETHERAPY INFORMED CONSENT**

I understand that online counseling services include, but are not limited to, consultation, treatment, and using interactive audio, video, or data communications. I understand that online counseling services involve the communication of my medical/mental information, both orally and visually, to health care practitioners that may be located outside my local area or state.

**I understand that I have the following rights and responsibilities with respect to online counseling services:**

*1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.*

*2. I need to be physically present, at the time of service, in a state in which my therapist holds a professional license*

*3. The laws that protect the confidentiality of my medical information also apply to online counseling services. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed intent to harm myself, and where I make my mental or emotional state an issue in a legal proceeding.*

*4. I also understand that the dissemination of any personally identifiable images or information from the online counseling services to researchers or other entities shall not occur without my written consent.*

*5. I understand that there are risks and consequences from these services, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.*





*6. In addition, I understand that online counseling services may not be as complete as face-to-face services. I also understand that if the counselor believes I would be better served by another form of counseling services (e.g. face-to-face services) I may be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of counseling services, and that despite my efforts and the efforts of the counselor, my condition may not improve, and in some cases may even get worse.*

*7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.*

*8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.*

*9. I understand that I may benefit from online counseling services, but that results cannot be guaranteed or assured.*

*10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.*