RESOURCE COUNSELING CENTER CLIENT INFORMATION FORM

COUNSELING PHILOSOPHY

I am a licensed psychologist providing care for people who experience a wide range of emotional, behavioral and interpersonal problems. At times my work extends beyond problem-solving to helping those I see improve the quality of their lives and relationships leading to greater joy, fulfillment and purpose.

As a psychologist I respect and utilize the ideas and tools of my profession -- its theories, methods and tests. However, my philosophy of counseling is also influenced by the Christian faith which undergirds my core values and beliefs. As counseling at its best is an open and honest sharing of thoughts and experiences, I invite counselees to feel free either to include or not to include discussion of their faith journeys in counseling sessions. While some seek therapy that has a spiritual component, others benefit most from experiences which are definitively clinical.

PAYMENT POLICY

All fees, including co-payments, co-insurances and charges to be applied toward deductibles are to be paid at the time of service. Any other arrangements must be made in advance (including post-dated checks). Testing services and educational materials are in addition to the regular fees.
Fees are based upon 53-60 minute sessions.

Diagnostic Interview	$210
Individual Session	$185
Family Session	$185

TELEPHONE CALLS

If phone contact with me between sessions becomes necessary, I will respond as quickly as possible. Calls need to be for acute needs and not as a substitute for counseling. Phone calls lasting 15 minutes or longer will be charged to you as insurance does not cover this service.

CANCELLATIONS - MISSED APPOINTMENTS

I must receive notice of a cancellation by noon on the business day immediately prior to your appointment. Missed appointments and late notice cancellations are subject to an administrative charge of $85 for the first two times, $170 for subsequent times.

_____
Initial

INSURANCE

Many insurance policies provide coverage for mental health services. If I have a contract with your insurance company, your financial responsibility is limited to deductibles, co-payments and co-insurance. If I am not contracted, your account will typically be your full responsibility. Please notify me promptly should your insurance change. Failure to notify me of a change will usually result in temporary loss of coverage.

_____
Initial

CHILDREN

I ask that children under the age of 10 not be left unattended in the waiting room.

CONSULTATION

I have the right to disclose selective information about your care in order to obtain payment for services (e.g. to your insurance company) and to provide for emergency situations unless you specifically refuse to allow me to do so. While the law does not require you to agree to these conditions, I am not bound to provide services if you refuse to do so.

_____ Yes, you may disclose health care information under these conditions.
_____ No, I refuse to grant consent for such disclosures.

CONFIDENTIALITY

Confidentiality of the counseling provided by me is protected by law. I will not notify anyone that you are receiving counseling. A **RELEASE OF INFORMATION** must be received from the client to disclose information. According to the laws of the State of Nebraska and the United States of America, however, confidentiality may be breached:

1. If you pose a serious physical danger to yourself.
2. If you pose a serious danger to another person.
3. If you disclose that you or another person has physically or sexually abused a child, an incompetent person or a disabled person.
4. If you disclose that a child, an incompetent person or a disabled person is suffering because of neglect.
5. If there is a court order compelling the release of information.

I am required to report abuse or neglect if it is disclosed under the conditions given in (3) and (4) to an appropriate government agency.

FINANCIAL AGREEMENT/AUTHORIZATON FOR TREATMENT

I authorize treatment for the person named below and agree to pay all fees and charges for such treatment. I agree all charges for myself/members of my family will be paid promptly unless other arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. I authorize release of any medical information necessary to process my insurance claim and authorize payment of benefits to **ReSource Counseling Center** if my provider participates in my insurance plan. I attest that I have read both sides of this information sheet and I understand the conditions as stated, and agree to contract for counseling under these conditions.

_____	_____
Print name of Counseling Client	Print name of Legal Guardian
_____	_____
Signature of Client	Signature of Legal Guardian
_____	_____
Signature of Witness	Date

Ned Stringham, Ph.D.

Licensed psychologist