COASTAL COUNSELING CENTER, P.C.
INDEPENDENT CONTRACTOR AFFILIATES

PERMISSION FOR TREATMENT AGREEMENT/ FINANCIAL AGREEMENT

FEES: $130.00 PER INTAKE ASSESSMENT BY THERAPIST
$125.00 and $100.00 THERAPY SESSIONS
$200 PER INTAKE ASSESSMENT BY MD
$95.00 FOR MED CHECKS

As a courtesy, Coastal Counseling Center (CCC) will file insurance claims on behalf of the patient for services rendered by either an employee or independent contractor affiliate. We recommend that you call your insurance company to verify your coverage. Payment is required at the time of service. We ask that you pay for each session at the beginning of the session. Cash, credit cards, or personal checks are accepted for payment

THE RESPONSIBLE PARTY: The patient is responsible for the copayment at the time of each visit, which is the estimated amount not paid by the insurance company and includes unpaid deductibles. Any outstanding balance that is not paid by the insurance company due to denied claims, terminated policy, or uncovered service will be billed to the **patient/responsible party**. The patient/responsible party, not the insurance company is ultimately responsible for the payment of services rendered.

***CANCELLATION/NO SHOW POLICY*:** It is understood that a charge of $**50.00** will be charged to the patient/responsible party for any appointment missed or not cancelled within 24 hours **(Insurance does not pay for missed/cancelled appointments)**.

RETURN CHECK FEE: It is understood that there will be a charge of **$40.00** for any returned check, in addition to the check amount.

DOCUMENT/PHONE CALL FEES: There will be a charge of **$25.00 - $100.00** for letters requested of the therapist by the patient, paid in advance. Insurance does not pay the fee. If the patient wants us to speak, meet, or correspond in anyway with another person to include but not limited to an attorney, probation officer, CPS worker, physician, etc., the patient will be billed for the therapist's time.

COURT APPEARANCE FEES: If a therapist or any staff is subpoenaed to testify, the charge is a minimum fee of **$750.00** (nonrefundable), payable in advance, regardless of whether we actually testify or appear in court. The first $750.00 applies to a maximum of three hours of our time. If we are required to be on call beyond the three hours for court appearances, an additional $750.00 minimum fee will be incurred even if we must remain on call for one minute, one hour, or all three hours whether we testify or not.

DELINQUENT ACCOUNTS: Collection procedures will be initiated should your account become delinquent. I agree to waive all homestead deed exemption rights and pay court cost of all collections including 33 1/3% attorney fees and interest of 1.5% per month (18% per annum) on all unpaid balances due after 30 days.

I attest that I understand and agree to the above provisions and conditions, and I hereby authorize Coastal Counseling Center, P.C. and/or my therapist (Independent Contractor associated with CCC), to provide counseling and psychotherapy treatment, including medical treatment for myself or my child by those duly licensed in the Commonwealth of Virginia. I agree that CCC and/or my therapist may release information pertaining to treatment for insurance purposes and authorize my insurance company to pay my benefits directly to CCC for services rendered.

Patient: _____ Responsible Party: _____ Date: _____

Coastal Counseling Center, PC
1417 North Battlefield Boulevard, Suite 260
Chesapeake, Virginia 23320
757-436-0605 (Voice) 757-436-0023 (Fax)

APPOINTMENT CANCELLATION/LATE POLICY

A fee of $50.00 will be charged for failure to show for an appointment OR late cancellations (day of appointment). This fee will not be submitted to your insurance company and will be your responsibility.

Our request is that you cancel your appointment **24 hours in advance** so we can fill your time. If you realize the evening before your appointment that you are unable to come, please call 757-436-0605 and **leave a message** on the voicemail. Our support staff will attempt to fill the appointment time early the following morning.

Missed appointments and last minute cancellations affect the schedule of the clinicians and take an appointment from clients who have a desire or an emergency to be seen.

I _____ am fully aware of the cancellation/late policy.
Patient/Client's Name

Patient or Responsible Party Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

I hereby acknowledge that I have received or have been given an opportunity to read a copy of COASTAL COUNSELING CENTER & INDEPENDENT CONTRACTOR ASSOCIATES Notice of Privacy Practices. I understand that if I have any questions, I can contact my therapist or physician.

_____

Signature of Patient/Client ***Date***

_____

Signature of Parent, Guardian or Personal Representative ***Date***

_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc)

□ **Patient/Client refuses to Acknowledge Receipt:**

_____

Signature of Staff Member ***Date***

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APPOINTMENT AUTHORIZATION

Please note: Coastal Counseling Center will not share any clinical information without a specific release signed by you and released by your clinician.

Please help us protect your privacy by providing us with the name(s) of the people you would like us to share appointment information with. The person(s) you delegate below will be noted in our appointment system and will be authorized by you to confirm and make amendments to your appointments only.

If the patient is a minor, please note all responsible parties that are permitted to make, change, or confirm appointments.

AUTHORIZED PERSON(S):

If **NO ONE** is authorized to know about the appointments, write "**NONE"**

NAMES	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

In the future, should you have any changes in this information, please inform the front office staff so we can note your patient profile immediately.

_____

Signature of the Patient or Responsible Party Date

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Primary Care Release Form

(Please Print)

Patient Name:_____ **Date of Birth:**_____/_____/_____
(Month) (Day) (Year)

Patient's Address:_____

Employer Name:_____ **Insured's ID Number:**_____

Patient's Address:_____ **Custodial Parent:**_____
(if different than insured)

Primary Care Physician:_____ **Address:**_____

City:_____**State:**_____**Zip:**_____ _____

Release for Coordination with Primary Care Physician:
For the purpose of coordinating care, my mental health provider may release pertinent information about my current treatment to my primary care physician. This release shall be valid until sixty (60) days after my last date of treatment OR until the time I revoke this release, which can be done at any time.

(Check One) **I do _____ I do NOT _____** give permission to the provider named below to release information about my current treatment to my primary care physician.

Patient (Guardian) Signature:_____**Date:**_____

Signature of Witness:_____**Date:**_____

(Providers Only)

Initial Summary (For all Providers) Date of Initial Visits:_____

Diagnosis (DSM-V) Axis I_____ Axis II_____

Current Medication(s):_____

Presenting Problems/Symptoms:_____

_____

Treatment Plan/Recommendations:_____

_____

Medication Prescribed: _____

Provider Signature: _____ Provider#: _____ Date: _____

Provider Name (Print): _____