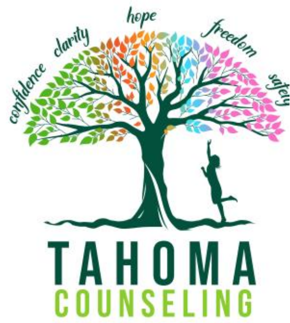




**Tahoma Counseling**

1346 Baldwin St.
Jenison, MI 49428

TahomaCounseling616@gmail.com
P: 616-765-8585
F: 616-333-8116

## Instructions:

**Please complete all six (6) of the pages as completely as possible. Please fill in as much information as possible using your computer or electronic device. You may type your name on the signature line and sign electronically. If for any reason you cannot upload to our portal, please print this form and sign signature lines using black or blue ink. Then bring this signed document in its entirety to your first session. We cannot provide services unless each line of this document is signed**

## Personal Information

| Today's Date: | |
|---|---|
| Client Full Name: | Preferred Name: |
| Address: | Home Phone: |
| City: State: | Cell Phone: |
| Zip: | E-mail: |
| Date of Birth: | Gender: |
| SSN: | Sexual Orientation: |
| Marital Status: | Preferred Pronouns: |

| Is client a minor? Yes No **If yes, please complete the following: |
|---|
| Parent Name: |
| Parent Phone Number: |
| Parent E-mail: |
| Parent Address (if different from above): |

May we call and/or leave a message on your home phone? Yes No
May we call, leave a message, and text you on your cell phone? Yes No
May we e-mail you? Yes No

Tahoma Counseling uses e-mail as a primary method of communication. By signing below you give us permission to e-mail you at the e-mail listed above. You also acknowledge that you understand that e-mail is not always a secure method of communication and Tahoma Counseling is not liable or responsible for any breaches of confidentiality that occur via e-mail. **Please note, Tahoma Counseling does everything in their power to reduce the likelihood of breaches of confidentiality and normally does not communicate sensitive or clinical information via e-mail.

______________________________________ ______

*Signature of Client/Legal Guardian Date



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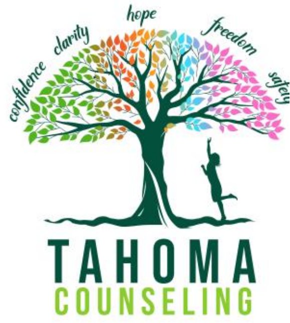


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**Emergency Contact**

Name: __________________ Relationship: __________________Phone number: _____

**Referral Information**

How did you hear about Tahoma Counseling? _____

## Insurance Information

| Primary Insurance: | |
|---|---|
| Policy Number: | Group Number: |
| Policy Holder: | DOB: |
| Employer: | |
| | |
| Secondary Insurance: | |
| Policy Number: | Group Number: |
| Policy Holder: | DOB: |
| Employer: | |

## Phone Calls

If there is a mental health emergency, please call 911 or go to the nearest emergency room. If there is an URGENT issue and you need to speak to your therapist please contact them at the number they provide you.

Please be advised that a fee is associated with phone calls lasting longer than 10 minutes. These fees are **NOT INSURANCE BILLABLE**. Fees are as follows:
<10 min call = No charge
10-20 min call = $20
20-30 min call = $40
30+ min call = $80

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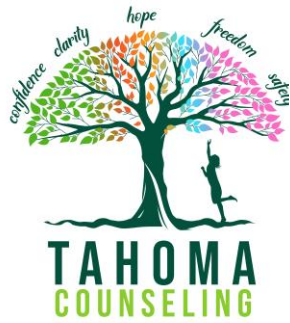




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## In Crisis Situations

Our clinicians are not crisis counselors and we do not have any on call clinicians. If you are in a crisis of any kind, please proceed directly to the nearest emergency room or call 911. You can also call the local Crisis Hotline at 1-866-512-4357 and someone will assist you promptly

______________________________ ____

*Signature of Client/Legal Guardian Date

## Attendance

When you make an appointment, Tahoma Counseling reserves that time for you. It is your responsibility to keep the appointment. Because our clinicians' time is valuable and reliably attending your sessions improves the effectiveness of treatment, there is a fee associated with missed appointments and appointments that are cancelled without at least 24 hours notice. The fees below are **NOT INSURANCE BILLABLE.** The fees are not penalties, but rather they are payment for the time you reserved with your clinician.

Late Fee: You will still be charged for the entirety of the session if you arrive late or leave early
Cancellation fee (without 24 hours notice): $75
No Show Fee: $75

I understand that 24 hours notice must be given for all cancelled appointments in order to avoid the $75 cancellation fee.

______________________________ ____

*Signature of Client/Legal Guardian Date

## Cost of Treatment

- Treatment is an investment in your health. Paying your bill is part of the investment in your health.
- Payment is due at time of service.
- Standard Billing Fees:
  - Initial Consultation = $250
  - Therapy Session = $200
- You are responsible for payment if your insurance company does not cover our services. It is your responsibility to confirm your insurance company will cover our services.
- If you would like to pay using cash, check, or card, lower fees are available upon request.
- Statements for any overdue balances are sent upon discharge from care and quarterly thereafter.
- If payment is not made after 30 days, your outstanding balance and necessary personal information may be sent to a collection agency or small claims court.

______________________________ ____

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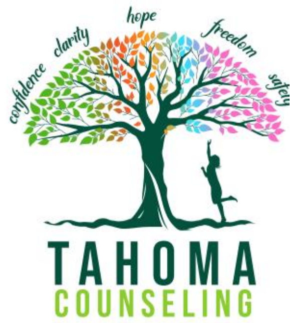


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## Paying for Treatment

Tahoma Counseling requires a credit or debit card be placed on file. You can put a card on file through our secure therapy portal. However, you do not have to use that card to pay for treatment. You can choose one of three options for paying for any costs associated with your treatment. We accept cash, check, credit/debit card, or HAS/FAS cards. We accept Visa, Mastercard, or Discover. Please notify your clinician of the specific method you wish to utilize.

I authorize Tahoma Counseling to charge my credit/debit card for the amount due for each session I attend.

I authorize Tahoma Counseling to make ongoing charges for the services I receive.

I acknowledge that the above card will be charged automatically in accordance with the above noted cancellation and no show fees.

If you have concerns about our payment policies, please don't hesitate to discuss them with your individual clinician. We never want money to be a barrier to receiving needed healthcare services. We offer sliding scale fees, payment plans, and are generally flexible with payment arrangements.

______________________________________ ______

*Signature of Client/Legal Guardian Date

## Acknowledgement

- Tahoma Counseling is a DBA under Tahoma Enterprises, which is a Limited Liability Company.
- Therapists working at Tahoma Counseling are independent contractors. Each therapist works independently of the others. Thus, you are a client of your therapist, not of Tahoma Counseling. No provider shall in any way be construed as a partner, shareholder, employee, associate, or agent of any other provider in this office.
- In accordance with Michigan law, the process for filing a complaint against any licensed or registered health care professional may be found at http://www.michigan.gov/lara.

______________________________________ ______

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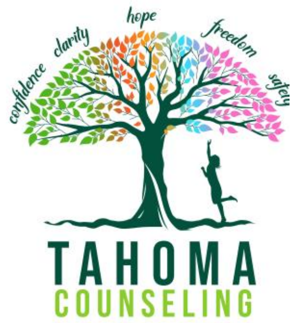


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## Release of Information

I hereby authorize the exchange of my clinical information between my insurance company, gatekeeper or primary insured person, primary care physician, and any other specialists to whom I would be referred for treatment under my commercial insurance, HMO coverage, or Employee Assistance Program. I authorize that when my therapist is uncertain of how to address a particular problem, they may seek advice from another therapist at Tahoma Counseling and identifying information may be disclosed if deemed necessary (That staff member is bound by the same confidentiality your therapist is bound by. The purpose of this disclosure is to ensure you are receiving the best treatment possible). I also authorize a quality-assurance review of my file contents by an appropriate member of the clinical staff. If my therapist is working under a limited license, I understand their work is supervised by a licensed supervisor at Tahoma Counseling.

______________________________________ _____

*Signature of Client/Legal Guardian Date

## Receipt of Privacy Practices

**(Available at tahomacounseling.com and on paper by request)**

I have received the Notice of Privacy Practices and my Rights/Responsibilities from Tahoma Counseling. I understand the information contained in this document, and I understand I can ask my therapist questions about it at any time.

______________________________________ _____

*Signature of Client/Legal Guardian Date

## Confidentiality

Your confidentiality is extremely important to us. Your paper records will be stored in a double-locked office cabinet unless they are in use by your therapist or clinic staff. Your clinical records will be stored via an online medical record program that abides by all rules and regulations set forth by HIPPAA for mental health records. No one outside of the exceptions listed below, will have access to your information.

- Your therapist is a mandated reporter of child abuse, elder abuse, and abuse of a disabled person. If you notify your therapist that an individual belonging to one of the above groups is being physically, emotionally, or sexually abuse, your therapist must report this to Child Protective Services, the police, and/or any other protective agencies.
- If you make statements that you intend to harm yourself or others, your therapist has a duty to protect you and other people. Your therapist will contact the police or any other individuals that he/she may need to contact in order to protect you and others from harm.
- In rare circumstances, your records could be subpoenaed by a court or a judge. Your therapist may have to release records in these cases. Your therapist will make a good faith effort to contact you and let you know if records must be released to a court or a judge.
- In the context of Couples Counseling or Family Counseling, your partner and/or adult children will have access to clinical information during the course of treatment.



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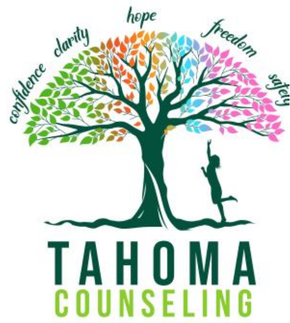




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I understand the above confidentiality policy:

______________________________________ ______

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## What to Expect from Treatment

- Counseling/psychotherapy is a process that occurs through a genuine relationship with a therapist. This process takes different amounts of times for different types of people and varies based on the nature of the presenting complaint.
- Counseling requires a commitment. Oftentimes weekly appointments will be needed to address your symptoms. It is important that you know that sometimes symptoms get worse before they get better. Therapy can be a difficult process. Oftentimes it takes significant effort and commitment to discuss the difficult topics that need to be discussed for you to move towards psychological health.
- We will discuss your specific goals and create a plan for how to achieve them. We will measure our success on a regular basis through subjective and/or objective reports.
- The therapy process is an individualized process, and it is important to be open and honest with your therapist about any concerns you might have. Your therapist is committed to providing you with high quality care and respecting your right to ask any questions you might have. We will answer all of your questions to best of our ability.
- Your records are kept strictly confidential apart from the permissions given in this document or in a separate Release of Information.

I have read and understand what to expect from the therapy process:

______________________________________ ______

*Signature of Client/Legal Guardian Date

## Consent for Treatment

- I voluntarily consent to engage in psychological treatment at Tahoma Counseling.
- I understand the risks and benefits to counseling and understand I can ask my clinician about these risks and benefits at any time.
- I understand I have the right to withdraw from treatment at any time.
- I understand that engaging in counseling is not an exact science and I acknowledge that no guarantees can be made regarding the outcome of treatment at Tahoma Counseling.

______________________________________ ______

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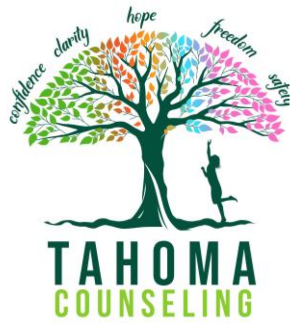


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## Consent for Treatment of Minors (If applicable)

- I give permission to my clinician at Tahoma Counseling to provide a mental health assessment and treatment services for this minor child: ___________. I am the parent, legal guardian, or otherwise legally responsible party for _____________.
- I understand the specific content of sessions between my child and his/her therapist will remain confidential and that my child has the right to request that information about his/her treatment not be shared with me. General progress regarding treatment will be shared with me.
- I understand that all information concerning danger or risk of severe harm to a child will be reported to parent(s), guardian(s), and/or police if necessary.
  H

_________________________________________ ______
*Signature of Parent/Legal Guardian Date



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