Name: ____ DOB: ____________________ Date: ___________

Provider: William Venable, MA, MDiv, LPC

Receipt of Notices and Request for Services

_____ I have read the attached Professional Disclosure statement for William Venable, MA, MDIV, LPC, an employee of LifeCare Counseling and Coaching.

_____ I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ I hereby request professional services from this professional. I understand the first one or two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable then a treatment plan will be agreed upon at the end of the evaluation.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to LifeCare Counseling and Coaching for all costs, charges and expenses incurred by said client at this office, unless separate arrangements are agreed upon in writing.

I also agree to pay a service charge of $30.00 for any checks that are returned unpaid. I understand if the patient balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent. In the event the account is turned over to a collection agency, I agree to pay a $10.00 collection fee which will be added to the existing balance. In the event legal action should become necessary to collect an unpaid balance due for services rendered to said patient, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Insurance/Managed Care/Third Party Payment

_____ I understand it is my responsibility to inform the office of any changes in my insurance, prior to the effective date of the change and accept financial responsibility for any office charges that were incurred prior to this date.

____ If I have third-party reimbursement, I understand it is only for the services they have agreed to cover. I understand that any additional services I desire are being provided outside this insurance arrangement, and I accept full financial responsibility for these services.

____ I certify the following information to be accurate:

___ **No Third Party Payer.** I have no insurance, or request that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

___ **Insurance/Out of Network, But No Contract.** I have insurance/third party coverage with:

____. I understand there is not a contract between this payor and the office for this provider's services. I accept financial responsibility for my bill regardless of whatever action my insurer takes. I request that claims be files with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office.

___ **Contract with Insurance/Third Party.** I have insurance/third party coverage with:

____. I understand there is a contract between this payor and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by my insurer.

____ ______________________

Client Date

____ ______________________

Legally Responsible Person Date

____ ______________________

Provider Date

1601 Jones Franklin Road, Suite 104, Raleigh, NC 27606 TEL (919) 851-1527 Fax (919) 851-3555

William B Venable, M.A., M.Div., L.P.C.
Professional Disclosure Statement

Credentials
B.A. in Psychology, University of North Carolina at Chapel Hill, 1986
M.A. in Marriage and Family Therapy, Reformed Theological Seminary, 1995
Master of Divinity, Reformed Theological Seminary, 1997
L.P.C., N.C. Board of Licensed Professional Counselor, License No. 3036, since 1998

Professional Experience and Services
Inpatient and outpatient therapy with adults, adolescents, and families since 1994, including therapy to individuals, couples, and families.
Provide individual and/or family therapy using family systems, developmental, and/or psychodynamic approaches. Techniques may include cognitive-behavioral, structures communication training or reframing.

Payment Policy
The issue of payment is always a question and we want to explain why we request *payment at the time of service*.

For reasons of their own, insurance companies are restricting the number of providers they allow to be part of their network. With the exception of a few companies, LifeCare is an out-of-network healthcare provider. Basically, this means your insurance company will not reimburse us directly for your services. It is also possible they will pay a reduced amount, generally about 70% of what they deem to be reasonable and customary.

It is our policy to receive payment for services at the time they are provided. We ask for the full amount of the service fee even if you have a policy with a fixed co-pay. As a convenience to you, we file your claim with your insurance company. The insurance company will then send the claims payment check directly to you.

Sometimes clients ask if they can bring the check to us once it is received. This has proven problematic for us in the past. In order to keep our costs competitive, we do not provide administrative oversight for billing services. This requires us to handle payment at the time services are rendered. Any exception to this policy requires agreement from your therapist and a written note of authorization be placed in your file. We greatly appreciate your understanding and cooperation with this request.

In surveying other practices in the area, our fee of $110 per session is in line or below the prevailing rates for professional licensed psychotherapy services. Some non-licensed Christian counselors may provide services for less, but here at LifeCare, we are committed to provide you with excellence in Christian counseling. Our counselors are well-trained, board certified, and experienced in dealing with a wide variety of needs. We sincerely appreciate the opportunity to help you with your current concerns.

Fee Schedule

Service	Fee
Psychotherapy 45-50 min (90806)	$110 (only this may be covered by insurance)
Psychotherapy 25-30 min (90804)	70
No-Show	Full Fee
Late-Cancellation	One-half of full fee
Telephone Consultation	Based on time required
Reports and Letters	Based on time required
Photocopying	Based on number of pages
Court Preparation/Appearances	$200

Payment, Insurance Reimbursement, and Problem Resolution
Payment is due at the time services are received. Cash, personal checks or credit cards (Master Card or Visa) are acceptable for payment. If you are unable to keep an appointment, please call to cancel by 12 noon the business day prior to your office visit. Otherwise, you will be charged a fee for the missed visit. No-show and late-cancellation fees are listed above.

The full fee is due at the time services are rendered unless I have a contract with your insurance company. If I have a contract with your insurance company, the co-payment is due at time of services after the deductible has been met. If I do not have a contract with your insurance company and my office has been submitting claims to your insurance company with successful collection, you may make arrangements for my office to continue to submit to your insurance company. The arrangement must include payment of the deductible and co-payment at the time services are rendered. If you wish to submit your own claims, my office will provide you with the necessary information and forms.

Health insurance companies require that I diagnose your mental health condition and indicate that you have an “illness” before they will agree to reimburse you. Any diagnosis made will become a part of your permanent insurance records.

If you are dissatisfied with any aspect of the services provided by me, please inform me so that we can address your concerns. If we cannot come to a satisfactory resolution, you may speak further with me or with Jerry Lankford, Office Manager. If after doing so you are still dissatisfied, you may contact the NCBLPC at P.O. Box 1369, Garner, NC 27529.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, I charge $200 per hour for preparation and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if I am compelled to testify by another party. An agreed upon amount will be rendered *in advance* and held in escrow. Any left-over amounts will be returned to you upon resolution of the legal matter.)

CONFIDENTIALITY

The confidentiality of your personal health information is very important to us. We may use and disclose your personal information without authorization for the following purposes: abuse, neglect, domestic violence, or court order.

As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse to self or others, neglect, domestic violence, or court order. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Please see "Notice of Privacy Practices" for more detailed information about confidentiality of service and records.

____ __________________________

Client Date

____ __________________________

Counselor Date