

Consent For Professional Services for LifeCare Counseling and Coaching

Main: 1601 Jones Franklin Road, Suite 104, Raleigh, N.C. 27606

(919) 851-1527 Fax (919) 851-3555

Brier Creek: 8801 Fast Park Drive, Suite 107, Raleigh, NC 27617

Chapel Hill: 1709 Legion Road, Suite 104 & 111, Chapel Hill, NC, 27517

Holly Springs: 190 Rosewood Centre Dr., Ste 100, Holly Springs, NC 27540

Triad: 14 West Main Street, Suite 317, Thomasville, NC 27360

Wake Forest: 1768 Heritage Center Dr., Ste 201, Wake Forest, NC 27587

Wilmington: 5020 Randall Parkway, Ste 4, Wilmington, NC 28403

Name: _____ DOB: _____ Date: _____

Scope of this Consent For Professional Services applies to **all providers** at LifeCare Counseling and Coaching. This means if any client or patient ends up seeing more than one provider at LifeCare, then those LifeCare providers can share information between each other on an as-needed basis.

Please **INITIAL** beside the following:

_____ I understand and agree that the recording of sessions without my provider's knowledge is **forbidden**.

_____ I have read the attached Professional Disclosure statement for my provider who is an employee of LifeCare Counseling and Coaching and 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.

_____ (Optional) I am willing to allow an intern to sit in on our sessions in that I understand that a mission of LifeCare is to train and license future counselors.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to LifeCare Counseling and Coaching for all costs, charges and expenses incurred by said client or patient at this office, unless separate arrangements are agreed upon in writing. I agree to have my credit card number on file for payment and authorize that card to be used to cover any unpaid balances.

_____ I also agree to pay a service charge of \$40.00 for any checks that are returned unpaid. I understand if the client or patient balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent.

For when the card on file does **not** belong to the client or patient: I, the financially responsible one, _____
(Print Name) (Signature)
give complete permission that the costs incurred by _____ and any outstanding balances now and going forward may be
collected by LifeCare using my credit card number. (Client or Patient Name)

Payment, Insurance Reimbursement, Cancellation Policy, Rates and Problem Resolution

It is our policy to receive payment for services at the time they are provided. Cash, personal checks, credit and debit cards are acceptable forms of payment. As a convenience to you, we will file your claim with your insurance company. If you are unable to keep an appointment, please call to cancel the business day prior 24 hours before your appointment. Less than that will be considered a late- cancellation. No call or not coming to your appointment will result in a No-show fee. The No-show fee is the full cash rate fee of the appointment and the Late Cancellation fee is half the cash rate fee of the appointment.

Rates. In surveying other practices in the area, our fee per session is in line with or below the prevailing rates for professional licensed psychotherapy services and psychiatric services. Rates are subject to change. 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.

We are in-network providers with Aetna and Blue Cross Blue Shield of North Carolina, except for Blue Local plans. Some of our providers are also in-network with United Healthcare/Optum and Cigna/Evernorth, but not all. Please check with your therapist or psychiatric provider regarding whether they are in-network for your plan. Please be aware that some insurance companies contract mental health benefits out to a different insurer who may be out-of-network. Your insurance company can confirm your benefits. Please inform us when you get a new insurance. Your insurance company can request your records, but this rarely happens.

We are out-of-network providers for all other insurance plans. As a convenience to you we will make every effort to file a claim on your behalf. If we are not able to file the claim, we will provide you with the appropriate receipt to submit to your insurance plan. We ask for the full fee at the time of service, then file the claim and assign payment of any benefits to come directly to you personally. We are **not** accepted providers for Medicaid or Medicare.

COURT PREPARATION/APPEARANCES:

If you become involved in legal proceedings that require the participation of a LifeCare provider, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement and clinical schedule readjustments, therapists charge \$300 per hour for preparation (psychiatrists charge \$500) and attendance at any legal proceeding. (You will be held responsible for payment for the professional time required even if we are 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.)

Insurance/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: (Check one below)

____ 1) **No Insurance**

____ 2) **Using Insurance, but Out of Network.** I have insurance/third party coverage with _____

____ 3) **Contract with Insurance/In-network.** I have insurance with _____

____ I authorize use of this form on all my insurance submissions.

____ I authorize release of information to all my insurance carriers.

____ I understand that I am responsible for my bill.

____ I authorize LifeCare to act as my agent in helping me obtain payment from my insurance carriers.

____ I authorize payment directly to my LifeCare provider, and hereby assign my right to reimbursement for services rendered to LifeCare Counseling and Coaching, P.C.

____ I permit a copy of this authorization to be used in place of the original.

Client or Patient

Date

Legally Responsible Person

Date