

Kelley Armbruster, LISW-S, PhD Candidate, FAPA, BCETS, LLC

Individual, Family and Group Counseling

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Parenting Coordinator

Therapist

513-770-0800-P

513-770-0888-F

Th3rapymurf64@cinci.rr.com

Consent to Treat Authorization/Fee Agreement

Welcome to my office! My name is Kelley Armbruster, LISW-S, LLC, I am a Licensed Independent Social Worker. I have been practicing for over 19 years. I provide counseling to individuals, families, couples and children. My areas of expertise are children and families of divorce, marital counseling, trauma work, depression and anxiety, and play therapy. I have experience in wide range of areas, and settings. The purpose of the information in this packet is to inform you of the policies of my practice. To ensure that you have read, understood and agreed to these policies, your signature is required on the second page of this sheet. I will provide you with a copy of these policies for you to keep for yourself.

Fees:

The fee for an initial consultation is \$120 (60 min). The standard 45-minute session is \$95, and \$120 for a 50 minute family or marital session. Every effort will be made to begin and end sessions on time. Please help me monitor the time so that I do not keep you or another client waiting. If you would like to extend the length of your sessions, you are welcome to do so as long as my schedule allows and preferably with sufficient notice. The rate of extension is \$25 per 15-minute increments. Please be aware that most insurance companies do not reimburse for sessions longer than 45 minutes. ***Co-payments/deductibles are due at the beginning of each session by cash, check, or charge. A \$5 charge will be assessed if the co-pay is not made at the time of service and a \$25 returned check fee per occurrence.***

You have two methods to choose from in paying for your counseling services: 1) Utilizing your health insurance. 2) Self-payment for services. **If you chose to use your health insurance, I require a credit card guarantee in the event that your insurance company fails to pay for services or you fail to pay your co-payments or other fees that are outlined on this fee agreement** (please fill out the "Credit Card Guarantee" as outlined below). If you chose to use your health insurance, please understand that this is an agreement between you and your insurance company. ***If your insurance company requires an authorization for your initial visit(s), please make sure that you have obtained this authorization no later than your first visit. If your insurance company denies your initial visit(s) because of no authorization you will be responsible for full payment for these visit(s).*** If I am **not** on your provider panel for your insurance company, you must prepay all charges. Our billing department will assist you in submitting insurance forms. If, however, your insurance company does not pay the anticipated amount, **you** are still responsible for the total amount of the bill. Please be aware that the insurance benefits quoted by your insurance company are not a guarantee of payment and may change or be denied later by the insurance company, depending on your health insurance coverage and the insurance company's policies. In the event your account is not paid in a timely manner, this may be reported to a credit-reporting agency. ***Denied insurance claims amounts are due 10 days after the date on the bill sent to you showing this denial, as allowed by the insurance company. Please make checks payable to Kelley Armbruster, LISW-S, LLC.*** The following penalties will be imposed on the Client for failing to pay Kelley Armbruster, LISW-S, LLC in a timely fashion. When your bill is 60+ days past due we will add to your bill an additional \$30 billing fee each month. If we have to refer the collection of your account to a lawyer or collection agency, you will be responsible for all costs of collection, including reasonable collection agency fees, attorney's fees and court costs.

The Therapist will be reimbursed for the following expenses incurred in connection with providing the therapy services, with a minimum fee (15 minutes) charged. Exceptions will be made for brief contacts about scheduling at the discretion of the Therapist.

- ***Paperwork completed outside of session.***
- ***Phone calls*** (Note: phone sessions are not be covered by your insurance).
- ***Reading or writing extended or numerous e-mails.***

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- **More complex reports, professional opinions, treatment summaries, or recommendations, etc., are \$175, including postage. *I reserve the right to adjust report fees according to individual circumstances.** (This fee must be paid before the report can be released to you or to any other party.)
- **Reading any reports (ie. psychological, legal, medical, or personal written narrative, etc.).**

Credit Card Guarantee:

Kelley Armbruster, LISW-S, LLC asks that you provide a credit card guarantee in the event that your insurance company fails to pay for services or you fail to make your co-payments or other fees that are outlined on this fee agreement. I want you to understand that I will only bill your credit card **after 30** days have passed since the provision of services and I have **twice sent you invoices**, giving you an opportunity to pay for services. When charging fees for the sessions covered by insurance, I will only charge for the contracted rate I have with the insurance, or managed care, company, minus any payments they or you have made on your claim.

Permission to Bill Credit Card

I am providing this credit card guarantee in the event that my managed care or Insurance company denies my claim, or I neglect to pay my co-payment(s), or for any other reason payment for services is not made. I do charge for all phone calls and am authorizing Kelley Armbruster, LISW-S, LLC to bill my credit card for any outstanding balance due 30 days after provision of services.

Master Card ___ Visa ___ American Express ___ Discover ___ Exp Date: _____

Card Number: _____

CV2# (3-digit code listed on the back of your card): _____

Name as it appears on the card: _____

Signature: _____

Court/Attorney Fees/Conferences with 3rd Parties:

In the event that I am subpoenaed or otherwise involved in proceedings because of my treatment of you, and/or it is required that I attend a conference with a 3rd party regarding my treatment of you, you agree to pay for my time at a rate of \$200 per hour, in addition to other costs and expenses associated with the subpoena or proceedings, including, but not necessarily limited to, travel time and attorney fees, expenses and hourly billing will begin at the time the provider leaves the office, in addition to any time that I might spend preparing for the proceeding. If mileage is charged it will be at the Federal reimbursement rate in effect at the time I incur the mileage). I require a \$1500.00 retainer 3-4 weeks prior to the court date to hold the court date and before I am able to testify or attend any court or other proceeding. If I do not receive the retainer I may not be able to attend, or I may have been subpoenaed for that date already. Paying the retainer guarantees me holding that date for your hearing date. In the event that my billing and costs reach or exceed \$950, you agree to advance additional amounts in \$500 increments, depending on what I determine to be expected costs and fees. By signing this form you accept the above information and are willing to pay the fees associated with legal proceedings.

The therapist may be asked to provide the court and/or the officers of the court with an interest in this case or information about the therapy. Any such report may occur in writing or verbally, or could be delivered in the form of depositions, affidavits, or testimony. Any such report would be provided only to reflect the facts of the treatment and the clinical opinions regarding the response of each person to the treatment. No opinions will be given beyond clinically derived opinions relevant only to the treatment, and those opinions will be limited to opinions about treatment.

Cancellation/No Show Policy

Your 45 minute session is reserved exclusively for you. You will be charged a fee of \$60 if you fail to show for an appointment the first time, and the full amount of the session charge the second time an appointment is missed (whatever charge that session would have been for that day). You will be charged \$25 if you are 20

minutes or more late for your appointment disallowing us to meet for your session. If you must cancel an appointment please do so at least 24 hours in advance, or you will be charged a late cancellation fee of \$50. These charges cannot be billed to insurance.

Emergencies:

If you leave a message for me, I am typically notified shortly of your call. If you are in an emergency situation and do not hear from me immediately then you must call the 24- hour crisis hotline at 281-2273, your primary care physician, your insurance company, or go to the emergency room so that you are safe and can receive the care you need. I try to return calls within 48 hours. However, I do charge for phone calls.

Confidentiality:

I understand that all information I disclose to my therapist is held in the strictest of confidentiality and may not be released without my written consent EXCEPT AS REQUIRED OR ALLOWED BY LAW. Some exceptions to confidentiality include, but are not necessarily limited to, situations where there is:

- A danger to yourself or another person, which requires or allows me to provide protection to you and/or the other person(s).
- Actual or suspected abuse or neglect of children/minors, developmentally disabled/mentally retarded individuals, and/or the elderly (Kelley Armbruster, LISW-S, LLC, is mandated or allowed by law to disclose this information to the proper authorities and/or other appropriate agencies).
- Presentation of a valid court order.
- In addition, you agree that at times I may need to discuss clinical situations/issues with my practice attorney. I may be required to send information on unclaimed funds to the appropriate state agency, and I may need to reveal information about you if I file a collection action **for any account that has gone unpaid for 90 days**. In all of these cases, I will reveal only the minimum amount of information necessary to accomplish each task.
- Further, you agree that I may disclose and/or obtain information about you for treatment purposes, i.e. with another therapist from whom I seek advice about your case and/or with another professional who is treating you or has treated you in the past. Please see my Notice of Privacy Practices for more information on confidentiality.

Billing Information/Treatment Termination:

All clients must complete and sign a client registration form. Your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations and then help me track the number of sessions allowed or you may be responsible for payment. Please inform me immediately of any change in insurance, personal address or phone numbers changes, as well as any employment changes. If you miss three scheduled appointments in a row or are not seen for more than three months, then you will no longer be considered an “active” client in my practice. If you wish to return for treatment, simply call me and your case will become active again at the time of your first appointment.

Insurance Disclosure & Consent

For those clients using their insurance to pay for therapy, a consultation with your attending/primary care physician and your insurance company may be needed. In addition, disclosure of your diagnosis, review of your treatment session, summaries and a review of your treatment plan may be required to access your insurance benefits. You may choose not to authorize the release of this information, however this may prevent you from using your insurance benefits. ***Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use those benefits.***

The Process of Counseling/Therapy:

Possible benefits derived from therapy include:

- A). Better ways to deal with social, familial and occupational relationships.
- B). Better personal adjustment and contentment.
- C). Better ability to cope with problems and stress,
- D). Better productivity.

It is believed that a better life is possible for most people and that an individual’s investment and commitment in therapy can determine the outcome. Therapy may also involve some feelings of discomfort. These feelings can

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occur when you begin to work on changing your beliefs and/or behaviors. This discomfort is viewed as a stepping-stone to a more effective and satisfying life.

You have the right to terminate services at any time and in that case I will be happy to provide you with the names of other therapists, or you may obtain them from your insurance company. Please discuss with me any problems that you are having with the therapy process. In addition, I reserve the right to terminate therapy with you if I feel that is appropriate under the circumstances, for instance if I feel that you might progress better with another therapist.

The Client, Guardian, or Responsible Party hereby gives permission to Kelley Armbruster, LISW-S, LLC to treat the client on the terms and conditions as set out in this agreement.

I/we fully understand the above agreement and freely agree to the above conditions:

Client's name (printed)

Client/Guardian/Responsible Party

Date

Client/Guardian/Responsible Party

Date