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WHAT YOU SHOULD KNOW ABOUT COUNSELING

What is counseling?

The word “counseling” is interchangeable with the word “therapy”.

- Counseling is a relationship in which a professionally trained person (therapist) helps you to better understand yourself and solve problems. Seeking counseling is not a sign of weakness. Many people find that professional assistance is a mature and positive step toward success.
- Counseling takes place in a private, secure, uninterrupted setting.
- Counseling is a collaborative process in which the therapist acts as a facilitator so that awareness and change can take place. One goal is for you to learn new skills to help you resolve your current problems and become more capable of solving new problems on your own in the future.
- Counseling involves talking about yourself, including your family and personal history as well as your thoughts and feelings.
- Counseling is also referred to as “therapy” or “outpatient mental health services”.

What to expect in the first session

After you have scheduled your first appointment, you may find yourself experiencing anxiety and wondering what you will talk about. This worrying is normal. Therapists are aware that meeting with a “stranger” to discuss personal concerns can be intimidating. Remember that your therapist is a trained professional who will work at establishing a comfortable and supportive environment for you. Your therapist will want to focus on you and may ask you a number of questions about yourself, your history and your current problems. An appointment “hour” is typically 53+ minutes and is scheduled on a weekly basis to begin with. Your therapist will also discuss your insurance coverage and/or payment arrangements with you. If the therapist determines that you would benefit from additional services, this will be discussed with you and referral(s) made.

What is expected of you?

- To attend sessions and let your therapist know 24 hours in advance if you will need to cancel and/or reschedule an appointment.
- To talk openly and honestly about yourself.
- To complete tasks or homework assignments.
- To let your therapist know if you have questions about the counseling or feel that you are not making any progress.
- To let your therapist or the business office know if you are having difficulty paying your bill.

What is a Treatment Plan?

During the course of counseling, the therapist develops a written Treatment Plan which is a plan of action based on the principles, methods and theories of counseling. The Treatment Plan is aimed toward the prevention, treatment and resolution of problems and/or mental health

disorders. The plan includes a descriptive statement of each problem and specifies goals, objectives and interventions. The purpose of a written Treatment Plan is to document the course of treatment, provide a structure for measuring progress, and allow for accountability. Client collaboration and cooperation is important for developing and complying with the Treatment Plan.

How is therapy paid for?

Depending on the type of education and experience of the provider, fees can range from \$50 - \$200 an hour. Many people have health insurance that includes some type of coverage for mental health services. You can discuss your coverage with your insurance company, human resource person at your place of employment, or with the therapist. Often, insurance covers a large portion of the fee and you have a co-pay. Managed care insurance plans may require authorization for services. You must sign an Authorization for Treatment and Billing Services form in order for us to bill charges to your insurance plan. If you are uninsured, your insurance does not cover counseling, or you chose not to use your insurance, you are responsible for full payment at the time of service. It is acceptable to discuss payment arrangements (credit card, special arrangements for payments, collection practices) with your therapist. If you would like to use a credit card to pay for services, you must complete a Credit Card Payment Consent form. This allows us to bill your credit card for services rendered. If you would prefer to pay by credit card without our involvement, you can do so by logging on to the website www.professionalcharges.com. Click on the "Make a Payment" button and complete the Payment Form. You will need to enter the Lakeview Counseling Tax ID number...383269851. Charges will appear on your credit card statement as "ProfessionalCharges.com".

Understanding the different types of therapists

- Psychiatrists are medical doctors (M.D. after the name). They have completed medical school and a residency in psychiatry. They are able to write prescriptions and administer medication(s).
- Psychologists have a Doctorate degree in psychology (PhD after the name) and are licensed to practice in their state. They have completed graduate school, including a doctoral program. They are able to provide a variety of forms of testing and therapy.
- Social Workers have completed a Master's degree in Social Work (MSW, LMSW, or ACSW after the name). They are licensed to practice in their state and have unique training in order to provide services for individual and family problems.

All therapists at Lakeview Counseling have completed the following education and training requirements:

- completion of a Master of Social Work degree or a PhD in Clinical Psychology
- completion of a minimum of 5 years postgraduate supervised clinical experience
- licensure as a "Certified Social Worker" or "Clinical Psychologist" with the State of Michigan
- membership in the National Association of Social Workers or American Psychological Association
- acceptance into the Academy of Certified Social Workers
- participation in continuing education activities

To file a complaint about a therapist, you can contact the State of Michigan, Department of Community Health, or the national association in which the therapist has membership.

Revised 12/2011

Lakeview Counseling, PC

WHAT YOU SHOULD KNOW ABOUT CONFIDENTIALITY

The security and confidentiality of all records is protected by both Federal and State law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) outlines regulations related to the release of information about you.

What is protected:

- any information about a person's health, health care or payment of health care--this includes mental health and behavioral health issues
- information that identifies a person
- information created or received by a covered health care plan or provider
- all medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally

Protected health information may not be disclosed by the clinic or a therapist without the informed and voluntary written consent or authorization of the client.

The clinic is required to obtain a client's consent for use or disclosure of client information for purposes of:

- health care treatment
- payment
- operations

Any conversations or communications you have with your therapist are private and confidential except under the following circumstances:

- disclosures required by law
- disclosure about victims of abuse, neglect or domestic violence
- emergency circumstances
- identification of the body of a deceased person or the cause of death
- permitted disclosures for public health activities (ie: reporting diseases, collecting vital statistics)
- research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board
- oversight of the health care system
- limited law enforcement activities
- judicial and administrative proceedings
- disclosure to avert a serious threat to health or safety; activities related to national defense and security
- case consultation (client name and demographics are not disclosed)
- audited review by your insurance carrier
- malpractice complaint or investigation

Please be aware that psychotherapy notes are held to a higher standard of protection because they are not part of a medical record and are never intended to be shared with anyone else.

Revised 12/2011

LAKEVIEW COUNSELING, PC
CLIENT REGISTRATION (Adult)

LEGAL NAME: _____ **Today's Date:** _____
Date of Birth: _____ **Age:** _____ **Sex:** ___ M ___ F
Social Security Number: _____
Address: _____ **email address:** _____
City: _____ **State:** _____ **Zip:** _____
BEST Contact Phone Number: _____
Name/age of others living in the home: _____

Employer: _____ **Work Phone:** _____
Marital Status: _____ **Spouse's Name:** _____
Spouse's Employer: _____ **Phone:** _____
Number of Children: _____ **Names/Ages:** _____

CONTACT IN CASE OF EMERGENCY: Name: _____ **Phone :** _____

Educational Level: _____ **Do you currently attend school?** _____
If yes, where: _____ **Grade/Major:** _____

PHYSICIAN: _____ **PHONE:** _____

Date of Last Physical Exam: _____

Were you sick but failed to get medical care in the last year? YES/NO

Did you miss more than ten days of your usual activity last year due to illness: YES/NO

Please list all MEDICATIONS you are now taking. Include those you buy without a doctor's prescription:

Medication Name	Dosage/ Frequency	Medication Name	Dosage /Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any ALLERGIES that you have: _____

HEALTH HISTORY

Please mark (X) any illnesses/medical problems you have, or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

Illness	X	Year	Illness	X	Year	Illness	X	Year
Alcohol Dependency		_____	Diverticulosis		_____	Liver Trouble		_____
Allergies		_____	Emphysema		_____	Migraine Headaches		_____
Anxiety		_____	Epilepsy, Seizure		_____	Mononucleosis		_____
Arthritis		_____	Glaucoma		_____	Pneumonia		_____
Asthma		_____	Head Injury		_____	Prostate Problem(s)		_____
Attention Deficit Disorder		_____	Heart Attack		_____	Ringing in the Ears		_____
Bipolar Disorder		_____	Heart Murmur		_____	Stomach Ulcer		_____
Bleeding Tendency		_____	Hepatitis		_____	Stroke		_____
Cancer/Tumor		_____	High Cholesterol		_____	Tuberculosis		_____
Cataract		_____	High Blood Pressure		_____	Miscarriage		_____
Colitis		_____	HIV/AIDS		_____	Deafness		_____
Convulsions, Seizures		_____	Diabetes		_____	Thyroid		_____
Kidney/Bladder Disease		_____	Depression		_____			_____

Have you ever been hospitalized? _____ If yes, please explain:

SUBSTANCE USE HISTORY

SMOKING: Do you currently smoke or use tobacco? YES/NO How much per day? _____
Are you a former smoker? YES/NO If YES, when did you quit? _____

DRINKING: Do you currently drink? YES/NO If YES, what kind(s)? _____
How much? _____ How often? _____
If you stopped drinking and/or are a recovering alcoholic, when did you quit? _____

DRUG USE: Do you, or have you in the past, used:
Cocaine YES/NO Marijuana YES/NO
Other Drugs: _____
Have you ever abused prescription drugs? YES/NO
Have you ever taken part in a drug or alcohol treatment program? YES/NO
If YES, please explain:

Have you been the victim of sexual assault or molestation? YES/NO

FAMILY HEALTH HISTORY Please give the following information about your immediate family.

<u>Family Member</u>	<u>Age if living</u>	<u>Age at Death</u>	<u>Status of Health or Cause of Death</u>	<u>Illness</u> (indicate which family member)
Father:	_____	_____	_____	Alcoholism _____
Mother:	_____	_____	_____	Drug Dependence _____
Brother(s):	_____	_____	_____	Anxiety Disorders _____
	_____	_____	_____	Bipolar/Manic Depression _____
	_____	_____	_____	Blood Disease _____
	_____	_____	_____	Cancer _____
Sister(s):	_____	_____	_____	Dementia/Alzheimer's _____
	_____	_____	_____	Diabetes _____
	_____	_____	_____	Epilepsy _____
Spouse:	_____	_____	_____	Glaucoma _____
Children:	_____	_____	_____	Heart Disease _____
	_____	_____	_____	High Blood Pressure _____
	_____	_____	_____	Rheumatoid Arthritis _____
	_____	_____	_____	Schizophrenia _____
	_____	_____	_____	Tuberculosis _____
				Other Disorder: _____

LEGAL HISTORY

Have you ever been arrested? _____ If yes, please explain:

Have you ever been on probation? _____ If yes, please explain:

Are you currently on probation? _____ If yes, please explain:

CURRENT PROBLEMS

Please state the reason(s) you are seeking services at this time: _____

Please mark (X) any of the following symptoms you have, or have had and indicate the year when each started. If you are not certain when a symptom started, write down the approximate year.

Symptom	X	Year	Symptom	X	Year
<u>Anxiety</u>			<u>Change in Desire for Sex</u>		
<u>Memory Difficulty</u>			<u>Panic</u>		
<u>Hallucinations</u>			<u>Irritability</u>		
<u>Anger/Temper Outbursts</u>			<u>Tearfulness</u>		
<u>Sleep Disturbance</u>			<u>Unresolved Grief</u>		
<u>Appetite Disturbance</u>			<u>Thoughts of Self-harm</u>		
<u>Lack of Interest in Usual Activity</u>			<u>Difficulty Concentrating</u>		
<u>Feeling Hopeless/Helpless</u>					
<u>Other:</u>					

Have you been involved in counseling before? YES/NO

Please indicate dates (year or your age) and who provided the services:

Please indicate any additional information you think is significant:

How did you learn of Lakeview Counseling?

Lakeview Counseling, PC
333 W. Grandview Pkwy, Ste 403
Traverse City, MI 49684

Please indicate how we may contact you:

Home: _____

_____ I give consent to leave messages on my voicemail.
Initial

Work: _____

_____ I give consent to leave messages on my voicemail.
Initial

Cell Phone: _____

_____ I give consent to leave messages on my voicemail.
Initial

Email: _____

_____ I give consent to send messages to my Email.
Initial

It is important to be aware that there are uncertainties related to the privacy and confidentiality of electronic communications. It is not advisable to use email or text for emergency situations. Emails and texts maintained as part of the client record. Lakeview Counseling, PC, is not liable for any breaches of confidentiality caused by the client or any third party.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS INFORMATION. I UNDERSTAND THE RISKS ASSOCIATED WITH THE COMMUNICATION OF EMAIL AND/OR TEXTS BETWEEN MY THERAPIST AND MYSELF AND CONSENT OT THE CONDITIONS OUTLINED.

Client Name: _____

Client Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

LAKEVIEW COUNSELING, PC
AUTHORIZATION FOR TREATMENT AND BILLING SERVICES

CLIENT NAME: _____

Date of Birth: _____

If minor child, name of Parent/Guardian: _____

I understand the following:

- * I am requesting outpatient mental health services at Lakeview Counseling.
- * These services are confidential and information cannot be released without my written consent.
- * If I feel my civil, treatment, or personal rights have been violated, I can report it to the *State of Michigan*, and/or the *Department of Mental Health*, and/or the *Department of Commerce*.
- * I am fully responsible for paying any fees not covered by my insurance company or other third party payment source.
- * Payment is required at the time of service unless other arrangements have been made. A monthly late fee may be charged if monthly payments are not received.
- * I must inform Lakeview Counseling of any changes in my insurance benefits.
- * I must give a *minimum* of 24 hours notice if I cancel an appointment. Failure to do so may result in a \$35.00 fee. Failure to keep an appointment may result in a \$35.00 fee.
- * Accounts which are delinquent will be subject to a collection process.
- * I must inform Lakeview Counseling of any changes to my contact information (i.e. address, name, phone numbers etc.)

I authorize the release of any information necessary to process insurance/billing claims as well as payment of all Mental Health insurance benefits to be made directly to Lakeview Counseling. I have received the Notice of Privacy Practices and have been provided with an opportunity to review it. I have been provided with the HIPAA information.

Client or Parent/Guardian Signature

Date

Spouse Signature (if conjoint therapy is taking place)

Date

FOR TREATMENT OF PERSON(S) UNDER THE AGE OF 18

Based on the laws of the State of Michigan and the guidelines of the therapist's profession, the rules concerning privacy will be used. I can maintain contact with the therapist via telephone or per a scheduled appointment time. I can request a written report or summary of services provided to the minor. I agree that I am the parent accepting responsibility for provision of insurance or other third party information and the payment of fees. I understand that Lakeview Counseling cannot charge or bill any other parent, guardian or third party entity without their permission.

My signature below means that I understand and agree with the points stated above.

I, _____, the parent/legal guardian
(Parent/Guardian Name) (Social Security Number)

of the minor, _____, give my permission for this
(Name of child/youth)

minor to receive therapy services at Lakeview Counseling, PC.

Client or Parent/Guardian Signature

Date

Lakeview Counseling, PC
BILLING INFORMATION

CLIENT NAME: _____

Address: _____

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

Telephone: _____

PRIMARY INSURANCE: _____

Contract #: _____ **Group #:** _____

Subscriber's Name: _____ **DOB:** _____ **SS#:** _____

Subscriber's Relationship to Client: _____ **Subscriber's Employer:** _____

Subscriber's Address if different than client's: _____

OFFICE USE:

Date Called: _____ **Spoke with** _____

Policy Year: Calendar/Renewal Month _____ **COB? Y N**

Deductible: _____ **Deductible amount met:** _____

Co-pay/ins: _____ **Unlimited Visits: YES or NO**

Authorization Required: YES or NO

SECONDARY INSURANCE: _____

Contract #: _____ **Group #:** _____

Subscriber's Name: _____ **DOB:** _____ **SS#:** _____

Subscriber's Relationship to Client: _____ **Subscriber's Employer:** _____

Subscriber's Address if different than client's: _____

OFFICE USE:

Date Called: _____ **Spoke with** _____

Policy Year: Calendar/Renewal Month _____ **COB? Y N**

Deductible: _____ **Deductible amount met:** _____

Co-pay/ins: _____ **Unlimited Visits: YES or NO**

Authorization Required: YES or NO

Lakeview Counseling, PC

**YOU CAN PAY YOUR BALANCE USING
Visa, Mastercard or Discover**

THREE SIMPLE STEPS:

- (1) Log onto www.professionalcharges.com
- (2) Click on the “Make a Payment” button.
- (3) Complete the Payment Form. You will need to enter the Tax ID # for
Lakeview Counseling, PC: **383269851**

Charges will appear on your credit card statement as professionalcharges.com

If you have any questions, please contact us.

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Credit/Debit/HSA/HRA Card Agreement

Lakeview Counseling, PC has implemented a policy which requires clients to pay for visits and copays at the time of service by cash, check or by choosing to use and maintain a valid Credit/Debit/HSA/ HRA card on file with us. All applicable No-Show or late cancellation (less than 24 hours) fees of \$35.00 will be charged to this card unless specified otherwise.

By providing us with your card information, you are consenting to Lakeview Counseling, PC to automatically charge the card on file for you, or any other client(s) listed below at the time of service or following a missed/late cancellation appointment.

Card Information

Credit/ Debit/HSA/HRA *Please circle type of card

Card Holder's Name: _____

Card Number: _____ Exp. Date: _____

CVV code: _____ (3 digit code on back)

I authorize the above card to be used for the following individuals:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

- I agree to the use of the card on file to be charged for all fee's acquired with my services at Lakeview Counseling, PC.**

Card Holder's Signature: _____

Date: _____