333 W. Grandview Pkwy, Suite 403
Traverse City, MI 49684
(231)929-0300 FAX: (231)933-6378
Website: lakeviewtc.com email: info@lakeviewtc.com

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 (Minor)

LEGAL NAME: ____ Today's Date: _______________

Date of Birth: _________________________ Age: ___________ Sex: _____ M _____F

MINOR'S SOCIAL SECURITY NUMBER: ____

SOCIAL SECURITY # and NAME OF PARENT/GUARDIAN: _______________________________

Address: ____

City:___________________________________ State: __________ Zip: _______________

BEST Contact Phone Number:___________________Contact Person:_______________________

CONTACT IN CASE OF EMERGENCY:

Name: _______________________________________Phone :_____________________________

Father's Name: ______________________________ Address: ________________________________

____ Phone: _____________________________

Mother's Name: ______________________________ Address: ________________________________

____ Phone: _____________________________

If child is NOT living with either parent, Name and Address of Guardian(s):

____

____

Name/age of others living in the home: ____

____

____

EMAIL OF PARENT/GUARDIAN: ____

DEVELOPMENTAL HISTORY

When the mother was pregnant with this child did she have (check all that apply):

____ Excessive Weight Gain ____ Bleeding or Spotting ____ High Blood Pressure

____ Measles, Mumps, Chicken Pox ____ Use of alcohol ____ Use of nicotine

____ Use of drugs ____ Other:

Any complications during labor and delivery:

Was the child premature? YES/NO

Did the child spend time in the hospital after birth? YES/NO

Details:

Any concerns about child's developmental milestones (sitting, crawling, walking, talking, etc.)

Revised 11/2011

HEALTH INFORMATION

PHYSICIAN: ______________________________ PHONE: ______________________

Date of Last Physical Exam: _____________

Was the child sick but failed to get medical care in the last year? YES/NO

Please list all MEDICATIONS the child is taking. Include those purchased without a Doctor's prescription:

Medication Name:	Dosage/Frequency:	Medication Name:	Dosage/Frequency:

Please list any ALLERGIES: ____

____

Has the child had (Please check any that apply):

____ Measles	_____ German Measles	_____ Mumps
____ Chicken Pox	_____ Scarlet Fever	_____ Rheumatic Fever
____ Polio	_____ Roseola	_____ Tuberculosis
____ Diabetes	_____ Pregnancy	_____ Whooping cough
____ Migraines	_____ Asthma	_____ Heart Problems
____ Cancer	_____ Diabetes	_____ Hearing Problems
____ Problems with Eyesight		_____ Epilepsy/Seizures
____ Attention Deficit Disorder		_____ Diabetes
____ Sexually Transmitted Disease		_____ Sexual assault/molestation
____ Problems with alcohol/drug use or abuse		_____ Problems with weight/eating

Other:

Has the child ever been hospitalized? YES/NO If yes, please explain:

FAMILY HEALTH HISTORY

Please give the following information about the child's immediate family:

Family Member	Age if Living	Age at Death	State of Health or Cause of Death	Illness (which family member)
Father:				Alcoholism ______________
Mother:				Drug Dependence ______________

FAMILY HEALTH HISTORY (continued)

Please give the following information about the child's immediate family:

Family Member	Age if Living	Age at Death	State of Health or Cause of Death	Illness (which family member)
Brother(s):				Anxiety Disorders ________
________				Bipolar/Manic Depression ________
________				Blood Disease ________
________				Cancer ________
________				Dementia/Alzheimer's ________
Sister(s):				Diabetes ________
________				Epilepsy ________
________				Glaucoma ________
________				Heart Disease ________
________				High Blood Pressure ________
________				Rheumatoid Arthritis ________
				Schizophrenia ________
				Tuberculosis ________
				Other Disorder: ________

SCHOOL INFORMATION

Is child currently in school? YES/NO Name of School: ____________________

Grade Level: ________ Any grades skipped ? ________ Any grades failed? ____________

Has the child been in special education classes/programs: YES/NO

If YES, please explain:

Did the child miss more than ten days of school last year due to illness: YES/NO

Does the child have any of the following problems in school? Please check all that apply:

____ Truancy/ Unexcused absences

____ Tardiness

____ Difficulty following directions

____ Aggression

____ Shy/ Withdrawn

____ Bullying

____ Relationships with peers

____ Relationships with adults

____ Difficulty completing assignments

____ Disorganization

____ Tired/lack of energy

LEGAL HISTORY

Has the child ever been arrested? ________ If yes, please explain:

Has the child ever been on probation? _________ If yes, please explain:

Is the child currently on probation? _______ If yes, please explain:

County of Probation: _____________ Name of Probation Officer: ______________________________

SOCIAL INFORMATION

Languages other than English spoken in the home: ____

Do you know or suspect that your child is harming him/herself physically?

Please list any of the child's stressful life experiences and include dates:

Organized activities in which child participates (ie: sports, scouts, clubs, music, camp, youth group (please list):

CURRENT PROBLEMS

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

Has the child been involved in counseling before? ______ If yes, please explain:

How did you learn of Lakeview Counseling?

____ ____________________

Signature of parent/legal guardian completing this Registration DATE

Problem Behavior Inventory for: ____ **Date:**______________

Please mark any problems that apply to the child

- ☐ Abnormal sexual development
- ☐ Abuse, physical
- ☐ Abuse, sexual
- ☐ Academic difficulties
- ☐ Alcohol use/abuse
- ☐ Anxiety, fears, phobias
- ☐ Attention seeking behaviors
- ☐ Argumentative
- ☐ Autistic
- ☐ Avoids physical contact
- ☐ Behavior problems in school setting
- ☐ Non-compliance
- ☐ Bossy
- ☐ Bullies/ intimidates others
- ☐ Low concentration/distractible
- ☐ Clingy, insecure
- ☐ Clumsy
- ☐ Compulsive exercise
- ☐ Conflicts with parents/authority
- ☐ Cries easily, whines
- ☐ Cruelty to pets or children
- ☐ Dawdles/lingers in:dressing,eating, bedtime, homework, chores
- ☐ Daydreaming
- ☐ Death/loss of loved one
- ☐ Dependency
- ☐ Depression
- ☐ Destruction of property
- ☐ Developmental delays
- ☐ Divorce (parents)
- ☐ Drug use/abuse
- ☐ Eating (binge/purge/starvation)
- ☐ Elective mutism
- ☐ Encopresis (soiling self)
- ☐ Enuresis(urinating at night or in clothing)
- ☐ Engages in dangerous/risky behavior
- ☐ Fire setting
- ☐ Forgetful
- ☐ Health/medical problems
- ☐ Humiliated/shamed
- ☐ Hyperactivity
- ☐ Hypochondriasis
- ☐ Imaginary playmates/fantasy
- ☐ Isolation, withdrawal
- ☐ Learning disability
- ☐ Legal difficulties
- ☐ Low self-esteem
- ☐ Lying
- ☐ Name calling
- ☐ Need for supervision at home
- ☐ Neglected
- ☐ Nervous habits (ie: nail biting)
- ☐ Nightmares/night terrors
- ☐ Poor toilet training/habits
- ☐ Obsessive
- ☐ Odd facial grimaces
- ☐ Oppositional
- ☐ Overactive/restless
- ☐ Relationships
- ☐ Removed from biological parent(s)
- ☐ Repetitive behavior/compulsions
- ☐ Running away, wandering off
- ☐ Sleep problems
- ☐ Self-abusive behavior
- ☐ Separated from siblings
- ☐ Sexual acting-out with others
- ☐ Sexually oriented play
- ☐ Shyness
- ☐ Speech difficulties
- ☐ Steals
- ☐ Swearing
- ☐ Temper tantrums
- ☐ Thumb sucking
- ☐ Tics
- ☐ Victim of sexual abuse
- ☐ Victim of rape or sexual assault
- ☐ Perpetrator of sexual abuse
- ☐ Perpetrator of sexual assault

☐ revised 12/2011

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Lakeview Counseling, PC

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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 adheres to the following policies regarding provision of services to children whose parents are divorced or in the process of divorce.

1. Parents with *legal custody* have the right to know that their child is receiving counseling services, the name of the provider and any relevant clinical information. Involvement and input from each parent is welcomed and can contribute greatly to the success of counseling.

Initial

________ The child lives with both parents, who have full legal custody.

________ I have sole legal custody of the child.
Lakeview Counseling may request proof that a parent has *legal custody* .

________ I have joint legal custody *

________ Other: ________ Foster Parent ________ Legal Guardian

* The Name and address of the other parent with legal custody of the minor child:

____
Name of Parent

____
Street Address

____
City State Zip Code

____
Phone Numbers with Area Code(s)

2. The parent/guardian giving permission for treatment is *responsible* for all therapy costs outside of those covered by a health insurance plan or other third party entity. Lakeview Counseling does NOT bill parents separately for portions of shared costs. **Parent/Guardian's initials** ________

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**

Revised 12//2011

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:________________________ **Unlimted 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:________________________ **Unlimted 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:______________

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