Fireweed Counseling and Wellness, LLC
4141 B Street Suite 301 Anchorage, Alaska 99504 • 907-830-9633
fireweedcounselingandwellness.com • eden@fireweedcounselingandwellness.com

Demographic Information

(If you are completing this for your minor child please use their information.)

Client's name: _____ Date: _____

Form completed by (legal guardian): _____

Date of birth: _____ Age: _____ Gender: Female Male

Transgender: Female Male Preferred pronoun: _____

Is there anything else that you would like to share with me regarding your gender identity?

_____

Physical Address: _____ City/Zip:_____

Mailing Address: _____City/Zip:_____

Client Phone Number:_____ Mobile Home Work

Legal guardian phone number:_____ Mobile Home Work

Email Address:_____

Legal guardian email address:_____

How were you referred? _____

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Insurance Information

Policy Holder Name (please print):_____Date_____

Gender: M F Policy Holder Date of birth: _____ Age: _____

Primary address: _____

_____

Guarantor (client or guardian, if client is a minor)

_____

Employer: _____ Occupation: _____

Health Insurance Company: _____

Address: _____

Phone number: _____

Identification number: _____ Group number: _____

By signing the two following bolded statements, I authorize Fireweed Counseling and Wellness, LLC to bill my insurance company using SIGNATURE ON FILE (SOF) as the authorizing signature.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Print Name: _____

Signature: _____

Date:_____

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Service Contract and Disclosure Statement

This document contains important information about my professional services and business practices. Please read it carefully and write down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

Counseling Services:

I am a Master level counselor with a graduate degree in counseling psychology from Alaska Pacific University with training and experience diagnosing and treating a variety of emotional and psychological problems. I have experience working with adolescents doing individual and family therapy, adults doing individual, couple, group and family therapy. I help clients overcome the following issues: transitional or major life changes, grief and loss, addiction issues, mood and anxiety disorders, trauma and dissociation, managing stress and emotions, attachment issues, personality disorders and somatic issues. I am trained in the following modalities: EMDR level 1 level 2, Breaking the Cycle-Advanced EMDR Training,Trauma Focused Cognitive Behavior Therapy (TF-CBT), Dialectical Behavior Therapy, Evidence Based Trauma Treatment and Intervention, UAA DV/SA training, STAR Crisis Line Training/ facilitator, Statewide Alaska Network on Domestic Violence and Sexual Assault training facilitator. I continually participate in on-going trainings and consultation groups for the above modalities as well as other areas of clinical interest to ensure that I am facilitating your treatment with the latest research and evidenced based practices.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant areas in your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who participate in it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are however no guarantees for a particular outcome even if you attend sessions on a weekly basis. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and most importantly outside of sessions.

Client Responsibilities:

Clients are responsible for payment for services.
We will discuss payment arrangements during the first session. Insurance billing may be processed by this office and if so I bill claims electronically and only bill primary insurance. Clients are responsible to pay for deductibles and copay/co-insurance at the time of service. Regardless of how someone choses to pay **I require clients to authorize me to keep their credit card information on file for agreed upon transactions.** If for some reason a client gets behind payment more than 30 days and arrangements for payment have not been made, then I will charge the credit card on file. If the credit card on file is declined then I will send the balance to a collection agency to secure payment. Personal information such as name, services provided, and amount due could be released. Note: I prefer to work through these issues together than use collection agency as a means to secure payment.

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Clients are responsible for attending sessions as scheduled.
Therapy sessions are by appointment only and because your appointment time is reserved only for you, it is necessary to charge for appointments **(no exceptions)** that are not canceled 24 hours in advance as I can often fill these appointments with notice. **Note: insurance does not pay for missed appointments. The fee charged for missed appointment is $100.** Please contact me at 907-830-9633; if I do not answer, leave a message stating you will be unable to attend the scheduled session. If you miss or cancel three sessions in a row you will be discharged from services due to non-participation.

Clients are responsible for their well-being.
Due to the nature of my business I am often not immediately available by telephone and therefore, unable to provide immediate crisis intervention. You are responsible for using your own crisis plan between appointments and during times I cannot be reached by telephone. If you do not have a crisis plan I will assist you to develop one. **If you are experiencing an emergency or are in crisis call the 24 hour Crisis Emergency Hot-line at (907) 276-7273, call 911 or go to our nearest hospital emergency room as they are prepared to handle psychiatric emergencies.**

Clients are responsible for communicating appropriately to receive full benefit of therapy. Email and texts will not be used for primary communication between the therapist and client. I do not do therapy by email or text message, since there is too much information I am unable to see or hear. If you prefer you may contact me via text message or email ONLY in regards to rescheduling, pending appointments, or if you are running late. **Note: email and text messaging is not a secure form of communication and because of the nature of the internet, I cannot guarantee your confidentiality if you choose to use this method.** Please let me know if you wish to contact me via email or text message as there is a special policy and information related to this. I check my voicemail daily and make every effort to return calls the same day but if I do not return your call the same day I will contact you via phone call or email the following day. Note: there are times that I'm unable to return your call that includes: Holidays and weekends (outside of my office hours). If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

Clients are responsible to not attend sessions under the influence to receive full benefit of therapy.
It is not necessary to "prepare" for a session, although clients may wish to do so. It is recommended that clients do not use mood-altering substances for at least 24 hours before our session, as this affects how you think and feel, and may impede your therapeutic progress. This includes, but not limited to, alcohol and marijuana. If you arrive intoxicated by a substance this may be a barrier to treatment and if so your appointment will be rescheduled.

Causes for discharge.
If a client threatens or reports that they plan to threaten myself, one of my family members or anyone in my office this will be cause for immediate discharge from my practice.

If a client assaults myself, one of my family members or anyone in my office this will be cause for immediate discharge from my practice.

If a client misses or cancels three sessions in a row, they will be discharged from services due to non-participation.

Services for Minors:
If you are under eighteen years of age, please be aware that the law provides your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else, have been assaulted, or are engaging in illegal activity which includes drug use. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, one or more family members in treatment sessions. A schedule for such sessions may be determined following the initial evaluation session or be set up on an "as needed" basis.

Therapist Responsibilities:

Protecting client confidentiality
I am required by law and ethical principles to protect your confidentiality. You may authorize me to release oral or written information regarding your care with others by signing a Release of Information form however there are a few exceptions which are as follows:

1. The law requires that I notify others if I judge that a client has made a clear threat of violence to an identifiable victim.
2. If I access that client is highly suicidal or unable to take care of themselves, I may notify proper authorities to arrange for hospitalization.
3. I am obligated by law to report suspected physical or sexual abuse or severe neglect of children, elderly or the handicapped.
4. In cases of criminal liability or child custody disputes, my records may be subpoenaed by a legitimate court of law. *
5. When insurance reviewers request information about your therapeutic progress, I will release information only as requested. *
6. I may release your name for bill collections processing. No treatment related content will accompany this disclosure. Since payment usually occurs at each session, this is very rare.
7. To provide my clients the best standard of care I periodically seek consultation and clinical direction from other professionals if this occurs, your confidentiality will be maintained and your name and identify will be disclosed only in compliance with AS 08.29.200. The consultants are also bound to keep the information confidential. If your case is discussed at consultation, a note will be placed in your clinical record.

*I will do my best to protect your confidentiality within the limits of the law. If you foresee any possible legal issues, such as divorce or custody battles, please inform me. I am not trained in the legal profession, I do not do forensic or parental evaluations and I prefer to stay out of the

courtroom. If I am called to court for any reason by a person/court in regard to your care, you are responsible for paying for my time and will be charged $1,500 for the court date and then my hourly rate if I am called to appear again thereafter.

* You should also be aware that most insurance companies require a clinical diagnosis to authorize services for reimbursement. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). Any requested information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

Professional Fees:

Psychotherapy, 45 min
50 minutes at $200
Default practice service

Psychiatric Diagnostic Evaluation
50 minutes at $300

Psychotherapy, 60 min
50 minutes at $200

Family psychotherapy, conjoint psychotherapy with the patient present
50 minutes at $100

Group Therapy
50 minutes at $100

Psychotherapy Add-on, 60 min
50 minutes at $200

Interactive Complexity Add-On
50 minutes at $100

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Please note: my professional fees will vary as I have various contracts with multiple insurance companies.

Cash, checks and credit cards are accepted forms of payment.

There will be a $25 charge for all checks returned for non-sufficient funds.

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or a summary of your visits can be prepared for you instead. Fees for documentation such as copies of records, letters or reports start at $35. If the time goes beyond 20 minutes, then I charge my hourly rate of $180 for the time it takes to complete your requested task. Please allow 1 – 2 weeks for your records to be prepared. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that we review them together so that we can discuss the contents; or I can send them to another mental health professional who is working with you.

Some of the information provided in this document is required by the Board of Professional Counselors which regulates all licensed professional counselors.

Board of Professional Counselors
Division of Corporations, Business & Professional Licensing
P.O. Box 110806 Juneau, AK 99811-0806
Phone: (907) 465-2551

Agreement and Consent for treatment

My signature below acknowledges that I have read and received a copy of the above material (counseling services, meetings, professional fees, payment and insurance reimbursement, contacting me, professional records, services for minors and confidentiality). I hereby consent to abide by the terms outlined above. I understand that I am responsible for all fees at the time of service unless other arrangements have been made in advance and know that I am free to ask questions at any time for clarification. I consent to treatment by Eden Lunsford, MS. LPC

_____

Client Printed Name and Signature Date

_____

Legal Guardian Printed Name and Signature Date

_____

Eden Lunsford Date

My initials below acknowledge that I have read, understood, and received the following:

_____Notice of Policies and Practices (HIPPA) Date_____

_____Service Contract and Disclosure Statement Date_____

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PATIENT RECORD OF COMMUNICATION AND DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). (See HIPAA policy)

In the event in which Eden Lunsford must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say my name or the nature of the call, but rather my first name or first and last name only.

If this information is not provided to me (below), I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information I will say that is it a personal call. I will not identify the clinic (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

I wish to be contacted in the following manner (check all that apply):

□ Home Phone_____
- □ OK to leave message w/detailed information
- □ Leave message w/call-back number only

□ Written Communication
- □ OK to mail to my home
- □ OK to mail to work/office

□ Work Phone:_____
- □ OK to leave message w/detailed information
- □ Leave message w/call-back number only

□ Fax_____
- □ OK to fax to this number

□ Cell Phone: _____
- □ OK to leave message w/detailed information
- □ Leave message w/call-back number only
- □ OK to correspond via **text ***

□ **Email*:** _____
- □ OK to correspond via this email address*
- □ OK for billing to use this email address*

***Note:** For all electronic means of communication this is a non-secure means of communication due to possible third party access and not HIPAA compliant.

My signature below acknowledges the fact that I have read the material and am informed about the above Alaska mental health laws, and the practices of this office. I understand the meaning and ramifications of the law, and know that I am free to ask questions at any time for clarification.

_____

Printed Name and Signature Date

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting Eden Lunsford. This authorization will remain in effect until canceled. **Please note** that the cancellation fee (if it applies) will be charged to this card on the date the services were supposed to be rendered. Additionally, any unpaid balance will be charged to this card (see service agreement for details).

Credit Card Information

Card Type: □ MasterCard □ VISA □ Discover □ AMEX

□ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Card CVV # (3 digit code on back of card):_____

Cardholder ZIP Code (from credit card billing address):_____

I, _____, authorize Fireweed Counseling and Wellness, LLC to charge my credit card above for agreed upon services and (if applicable) the cancellation fee and/or pending balance due. I understand that my information will be saved to file for future transactions on my account.

Customer Signature:_____ Date:_____