Wyndhurst Counseling Center
Counseling and Financial Agreements

We are so very sorry to lengthen this form, but our government has now made us include yet another section in our consent regarding stuff. Sorry.

Client's Name: _____ Date: _____/_____/_____

Important Information:

- I understand that if I cannot reach Wyndhurst Counseling Center that I can always call 911 or go directly to your local emergency department for emergency care. I may also contact the voicemail at the office number and will be directed to an emergency number with an on call therapist. I will do this should I believe I am at risk for hurting myself or someone else.
- I understand that I am to never schedule an appointment with Wyndhurst Counseling Center and my psychiatrist or another therapist on the same day because one of these will not be paid for by my insurance company. I understand that if I do this that I will be responsible for paying for the bill from Wyndhurst Counseling Center in full.

The staff at Wyndhurst Counseling Center (hereafter referred to as the clinic or WCC) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy with provides payment policies and options to all consumers.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company. As a service to you, the clinic will bill insurance companies/other third-party payers for some providers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases insurance companies/other third-party payers may consider certain services not reasonable/necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual/customary rates for the area. Clients are responsible for payments regardless of insurance company's arbitrary determination of usual/ customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services and is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days. I understand that I am responsible and agree to pay for any and all fees incurred for WCC and I am responsible for any/all collection fees and attorney fees when the account is turned over for collection to an attorney whether or not suit is filed.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductibles may have been met elsewhere (e.g., if there were visits to another mental health provider since billing year began, that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company/ third-party provider. All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized by a charge card. Payment methods include check, cash, or the following charge cards: Visa/MC/Debit. Clients using charge cards may sign a document allowing the clinic to automatically submit charges to the charge card after each session. I understand that if I write a check with insufficient funds I will incur a charge of $40. I (we) have read, understand, and agree with these.

Person responsible for account: _____ Date ____/_____/_____

Co-responsible party: _____ Date ____/_____/_

Payment Contract for Services:

Part One: Fees for Professional Services

I (we) agree to pay Wyndhurst Counseling Center, hereafter referred to as the clinic, per clinical unit (defined as 45-50 minutes for assessment, testing, and individual, family, and relationship counseling), one of the following rates:

- $ **115.00** with a Licensed Professional Counselor or a Licensed Marriage and Family Therapist
- $ **140.00** with a Licensed Clinical Psychologist
- $ **65.00** with a Pastoral Counselor
- $ **20.00** with a Counseling Intern or Resident in Lynchburg

A fee is charged for missed appointments or cancellations with less than 24 hours' notice. This fee is equal to the above mentioned rates.

Part Two: Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Person responsible for account: _____ Date_____/_____/_____

Release of Information Authorization to Third Party:

I (we) authorize Wyndhurst Counseling Center to disclose case records (diagnosis, case notes, psychological/testing results, and any/all information regarding alcohol and/or drug use/abuse or other requested material) to the third-party payer or insurance company for the purpose of receiving payment directly to Wyndhurst Counseling Center.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice. I (we) have been informed that information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and understand that a copy may be obtained upon request.

Person(s) responsible for account: _____ Date_____/_____/_____

Person(s) receiving services: _____ Date_____/_____/_____

Person(s) or guardian(s):_____ Date_____/_____/_____

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The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of nonemancipated minor clients have the right to access the client's records.

Client's name (please print): _____

Client's (or guardian's) signature: _____ Date: _____/_____/_____

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals outside WCC in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Due to the nature of working within an organization, some cases, including identifying information, may be discussed between clinicians from time to time to maximize effective care. If more than one member of a family is receiving care, consultation between clinicians may take place in order to best provide treatment for the family system. (Example: One clinician may be providing marital therapy and another clinician may be providing individual therapy to the husband or wife. Consultation between those treating professionals may take place) without a release of information being signed. There is no effective way to have a release of information to and from the same organization).

If an individual changes therapists, I understand that my file will open and available to the new therapist.

In the event in which the clinic or mental health professional must telephone/text/email the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please make sure that the number(s) that we have on record are the only phone numbers that you desired to have us call. In other words, if there are numbers that you do not desire to be contacted, please alert the office staff of this so that the numbers can be deleted from our system.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client's name (please print): _____

Client's (or guardian's) signature: _____ Date: _____/_____/_____

Wyndhurst Counseling Center, LLC
105 Hexham Drive
Lynchburg, VA 24502
Phone: 434.237.2655
Fax: 434.237.4422

Treatment Contract

I give my permission for the therapist of Wyndhurst Counseling Center, LLC (WCC) to provide counseling services to me and/or my family. In providing this informed permission, I understand that it would impede the counseling process if the therapist and/or the clinical records are requested or required by subpoena to be presented to the Court or the attorneys. Therefore, I agree that I will not request or require the therapist to testify in Court matters regarding me and/or my family, nor will I request or require (by subpoena) that the therapist's records be presented to the Court or the attorneys involved with my family. I also agree that I will never allow for an attorney to request that a judge or any other court official subpoena records or any person connected to WCC. If I refuse to sign this contract, I understand that the therapist has a right to refuse treatment to me and/or my family, given that he or she cannot provide quality services under these conditions. I understand that this agreement may only be negated by the therapist, if he or she feels it would be in the best interest of me or my family to testify in Court or present clinical records to the Court.

I understand that if by some means, I find a way around the above portion of this contract and have any therapist or staff member from WCC subpoenaed for any reason to any court procedure, I agree to immediately pay to WCC a fee of $2,500. In addition to this, I agree to pay WCC in the amount of $225 per hour, over and above, this $2,500 fee for any and all fees related to this endeavor, including but not limited to record review, travel time, travel expenses, and time spent in court. In addition to the above fees, for any date that a member of WCC receives a subpoena, I agree to pay WCC the amount of $1,800 ($225 x 8 hours). If the court hearing is cancelled or rescheduled, I clearly understand that I will pay this amount anyway. If another court date is scheduled and a subpoena is again sent, I clearly understand that I will immediately pay another $1,800. I agree to pay the amounts listed above regardless of whether the subpoena is generated by me, an attorney or a judge.

_____ _____

Signature Date

_____ _____

Signature Date

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I (we) authorize WCC TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

(Information related to the scheduling of meetings or other appointments, Information related to billing and payment, completed forms, including forms that may contain sensitive, confidential information information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment, my health record, in part or in whole, or summaries of material from my health record).

BY THE FOLLOWING NON-SECURE MEDIA:

Regular Email (Unsecure email).
Regular SMS text message (i.e. traditional text messaging) or other type of Unsecure "text message."
Regular Cell Phones (Unsecure cell phones).
Other media.

Please know that if we use electronic communications methods, such as email, texting, online video, cell/mobile phones, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

TERMINATION: This authorization will terminate when you notify WCC in writing that you would like it to end.

I (we) acknowledge that this is informing me (us) of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means.

WCC suggests that there not be contact between clients and clinicians via any form of social media such as Facebook, Linkedin, etc.

Client's name (please print): _____

Client's (or guardian's) signature: _____ Date: _____/_____/_____

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I authorize (Wyndhurst Counseling Center) to keep my signature on file and to charge my:

_____ VISA _____ MASTERCARD _____ DEBIT CARD

We are very sorry but due to cost, if you choose to use American Express or Discover, there will be a 4% service fee added.

Account for:

_____ Recurring charges (ongoing treatment) as per amounts stated in the signed Payment Contract for
(Initials) Services with this clinic.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's name: _____

Cardholder's name: _____

Charge card number: _____

Expiration Date: _____/_____

Cardholder's signature: _____ Date: _____/_____/_____

If you are receiving services at our ***Charlottesville Campus*** you must keep a card on file with us. We are unable to accept cash and checks at this location.

****ONLY IF YOU WISH TO USE DEBIT/CREDIT CARD AS PAYMENT****