Fig Tree Counseling LLC
1539 E 100 N
Kokomo IN 46901
Phone: 765-400-3678 Fax: 765-450-6353

WELCOME! Thank you for choosing Fig Tree Counseling LLC to assist you in your life goals. You can schedule with your provider at 765-400-3678 to schedule your future appointments. You can leave a message for us to return your call if we are unavailable to answer the phone. I have provided you with some additional information about what to expect while receiving treatment with us.

INITIAL APPOINTMENT
Your first appointment will be with a therapist. The therapist will complete an assessment covering your needs and strengths in areas of your physical, mental, emotional, and spiritual life. The therapist will discuss with you the services offered at Fig Tree Counseling LLC. Together, you and your therapist will identify treatment goals and a plan on getting those goals met. This initial appointment will last 45 min to 50 min.

APPOINTMENTS
Based on your treatment goals, you will be attending outpatient appointments with a Mental Health Counselor. These appointments are 45-50 minutes in length. The frequency of your appointments will be reflective of your individualized need. Appointments are available during the day and evenings.

NO SHOW/CANCELLATION POLICY
Due to our availability, it is important to keep scheduled appointments with your provider. We do understand life is often busy and other obligations come up. Our policy allows for one No Show appointment, however, after the second No Show appointment, there is a $35 fee that is to be paid prior to the next appointment. We request at least 24 hour notice for cancellations. Again, we understand situations can happen and this may not be possible. Late cancellations will be handled between you and your provider.

YOUR PATIENT RIGHTS
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. Please refer to client's rights handout provided to you by your therapist.

BILLING AND PAYMENT REQUIREMENTS
Fig Tree Counseling LLC does not accept insurance, as of yet. Please see the following for service pricing:

Counseling: $85 per 45-50 min session,
$40 per 25-30 min session,
*Fees for Services will be collected prior to each appointment.
**Please note that there may be other services that you require/request that are not covered by insurance and will be your responsibility to pay. These may include, but are not limited to, report writing, letter writing, court appearances, etc. These charges will be discussed with you by your therapist when request is made.

RISKS / BENEFITS TO THERAPY
Therapy can cause feelings to be surfaced that may have been suppressed for a long time. This can be often painful and challenging. The therapist will support you through this and provide you with skills to learn to cope with these feelings. Often times, things may get worse before they get better. The reason for this pattern is as we begin to deal and address painful areas in our life, difficult feelings are experienced. It may feel like these areas are best left unaddressed. However, the benefits of therapy and addressing these issues are greater in the end. To learn to face these challenges, gives you strength and frees you to engage in your own your life in an "awakened" state versus feeling "numb".
Providers at Fig Tree Counseling LLC have a great passion for life and a strong desire to support you in gaining a healthier and more fulfilled life.

Sincerely,
Elizabeth R Woodmansee LMHC
765-400-3678

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CLIENT RIGHTS

1. I have the right to decide not to enter therapy with the Fig Tree Counseling LLC. If I wish, names of other therapists will be provided.

2. I have the right to end therapy at any time. The only thing I will have to do is to pay for any treatments I have already had. I may, of course, have problems with other people or agencies if I end therapy— for example, if I were sent for therapy by the courts.

3. I have the right to ask any questions, at any time, about what we do during therapy, and to receive answers that satisfy me. If I wish, each method will be explained to me.

4. I have the right not to allow the use of any therapy technique. Upon my request the benefits and risk of each technique will be shared.

5. I have the right to keep what I tell Fig Tree Counseling LLC staff private. Generally, no one will learn of our work without my written permission. There are some situations to which Fig Tree Counseling LLC is required by law to reveal some of the things I report, even without my permission, and if Fig Tree Counseling LLC does reveal these things Fig Tree Counseling LLC is not required by law to tell me that it was done so. Here are some of these situations:
   A. If I seriously threaten to harm another person, Fig Tree Counseling LLC must warn that person and the authorities.
   B. If a court orders Fig Tree Counseling LLC to testify about me Fig Tree Counseling LLC must do so.
   C. If Fig Tree Counseling LLC is testing or treating me under a court order, Fig Tree Counseling LLC must report findings to the court.

D. If Fig Tree Counseling LLC wishes to record a session, Fig Tree Counseling LLC will get your informed consent in writing. I have the right to prevent any such recording.

E. I have the right to review my records in my file at any time, upon written request. If I disagree with anything documented in my records, I have the right to amend (not delete) my records.

F. **Minors and Parents:** Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, your therapist will provide them with only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Your therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless your therapist feels that the child is in danger or is a danger to someone else. In which case, your therapist will notify parents of his/her concerns. Before giving parents any information, your therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections he/she may have.

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CONSENT TO TREAT

_____ We/I agree to allow Fig Tree Counseling LLC to provide services to myself/our family. We/I understand that we/I may choose another provider for this service, and we/I have freely chosen to work with Fig Tree Counseling LLC.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS

_____ I authorize my provider to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my provider on my behalf.

We/I understand the purpose for and have completed the following or received the following information:

_____ Financial Contract/Payment Agreement

_____ Release of Information

_____ HIPPA

_____ Consent to Treat

_____ Client Rights

_____ _____

Client/Guardian's Signature Date

_____ _____

Staff Signature Date

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COORDINATION OF CARE FORM

Client's Name:_____ DOB:_____

Name of Primary Care Physician of Client:_____

Dear:

This letter is to only inform you that the above-named member was seen for initial behavioral health evaluation on _____

for _____
(reason/diagnosis)

Brief Summary (if indicated):

_____
_____
_____

Current Treatment:

- Psychotherapy
- Psychological Testing
- Other:_____

Sign if you consent to a letter of coordination to be sent to your Physician:

_____ _____
Client Signature / Date Signature of Provider / Date

_____
Signature of legal guardian / Date

I Decline to have a letter sent to my Primary Care Physician:_____

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PRIVACY NOTICE (HIPPA) ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information maintained here at Fig Tree Counseling LLC. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved in that treatment directly, or indirectly.

2. Obtain payment from third party payers.

3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have been informed by Fig Tree Counseling LLC of my right to privacy and obtained a copy of the Privacy Notice, which contains a more complete description of the possible uses and disclosure of my health information. I was given the right to review the Privacy Notice prior to signing this consent form. I understand that Fig Tree Counseling LLC has the right to change its' Privacy Notice at any time and that I may contact the organization at any time in order to obtain a current copy of the Privacy Notice.

I also understand that if I need more information or have questions, I may contact Fig Tree Counseling LLC at the number listed on the Privacy Notice. I understand that I may request in writing that Fig Tree Counseling LLC restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Fig Tree Counseling LLC is not required to agree to my requested restrictions, but if Fig Tree Counseling LLC agrees to my restrictions, then the organization is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Fig Tree Counseling LLC has taken action relying on this consent.

_____ _____
Client/Guardian's Signature Date

_____ _____
Staff Signature Date

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Medications Log

Name:	**Date:**	
Date of Birth:		
Allergies & Reactions:		
Pharmacy:	**Phone:**	**FAX:**
Other Medical Problems:		

Medications (Include OTC and Herbals)

Name, Dosage, and Instructions	Prescriber	Reason for Rx	Start Date	Stop Date	Comment /Codes *

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Patient Registration/Financial Agreement

Name:_____
(First) (Middle Initial) (Last)
Address:_____ **City:**_____**State**_____**Zip**_____

Phone:_____**(cell)**_____**Date of Birth:**_____

Email:_____ **Social Security:**_____

1. ***I would like a reminder call or email at least 24 hrs prior to each upcoming appointment?*** Y or N
2. ***This can be done by*****:** (circle) EMAIL or PHONE or BOTH.

Employer of Client or Guardian:_____ **Employer Phone:**_____

Emergency Contact:_____ **Phone:**_____

_____ (Initial) **I agree to a self-pay amount of $85 per (60 minute session). I agree to make the payment upon the time of the service. Until Fig Tree Counseling LLC is able to take my specific insurance then those arrangements will be made when insurance funding is made available.**

Signature:_____ **Date:**_____

Witness:_____**Date:** _____