Required forms of ID _____
Client's Name _____
Date of Intake: _____

Fee Schedule and Payment Agreement

Heads-Up Guidance Services is a Non-Profit organization providing professional behavioral health counseling and addiction recovery services at a discounted rate for all motivated individuals in need. We are a Fee-For-Service Provider and do not accept Insurance or Medicaid. **Fees are due at the time of service.**

Initial Intake: Application /Needs Assessment - $25

Initial Paperwork includes Personal History Profile, Current Assessment of Functioning, Informed Consent for Services, Legal Consent to Treatment, Level of Care/Counseling Regimen and Recommendations.

Please check the type(s) of service below that you feel will be most appropriate for you.

_____***Individual Counseling Sessions:***
45-50 minute individual session - $20

_____***Family/Couples Counseling Sessions:***
45-60 minute Family Counseling session - $30
45-60 minute Couples/Marital Counseling session - $30

_____***Group Therapy/Counseling/Psycho-Education Sessions:***
90 minute sessions - $15 per person

_____***Individual Assessments*:** Suicide, Substance Abuse, Anger Management or Mental/Behavioral
2 hours Including Intake-$75

Probation/Court Mandated Services

_____ ***Substance Abuse Assessment*** – 2 Sessions including Intake -$75
_____ ***Anger Management Assessment*** – 2 Sessions including Intake -$75
_____ ***Individual Substance Abuse Counseling*** - $35
_____ ***Individual Anger Management Counseling*** - $35
_____ ***8-Week (16 hour) Anger Management Course*** - $30 per Group/ $240 per Course
_____ ***8-Week (16 hour) Therapeutic Parenting Course -*** $30 per Group/$240 per Course
_____ ***8-Week (16 hour) Substance Abuse Course***- $30 per Group/$240 per course

Intensive Outpatient Services

_____ Comprehensive 12 or 24 Week Curriculum ($120 per wk -Includes 4 Group Sessions & 1 hr. Ind.)
_____ ***Urine Drug Screenings*** for Participants- $15

Intake Reviewed by: _____ Date: _____

Intake Audited by: _____ Date: _____

Payment Policy:

The fees listed may be adjusted annually. However, clients will be notified prior to any changes. **Payments are due in full at the time services are rendered.** Cash is the preferred method of payment, but personal checks and credit cards are accepted. There is a $30 charge for all returned checks, and returned checks will result in a "cash only" payment from that time forward. A **$2.00 fee is required for each credit card payment** to cover processing costs.

A Credit Card Authorization form must be kept in your personal file. This card will be charged for any appointments that you fail to keep without 24-hour cancellation notice.

There will be a charge of $25 for requests and duplication of clinical records to be released. There will be a *charge of $50 for* a written Treatment Summary.

Appointment Policy:

Counselors schedule all client appointments. When you confirm an appointment with your counselor, you are confirming payment for services. HUGS', therefore, requires that participants provide at least **24-hour notice when canceling an appointment.** Emergency Cancellations are NOT refundable because you are paying for the counselor's time. Clients who do not show up for appointments, and have failed to call to cancel, will be charged the full fee for those appointments. If you must cancel, please call the office at 912-417-4320. If the office is closed, you may leave a message on the answering machine.

***Availability:** Please list days & times most convenient for you to schedule appointments:

_____

Gift Giving Policy:

We encourage and acknowledge the desire of our clients to express gratitude. However, due to our ACA and NASW Code of Ethics, counselors are not able to accept gifts of any kind from their clients. (Counselors are required to decline any gifts beyond a cup of coffee.) If you feel inclined to contribute more, please make your tax-deductible donation to the HUGS' organization.

I have reviewed the fee and payment guideline listed above. I agree to accept financial responsibility for services provided, as well as for missed appointments that have not been canceled 24 hours in advance.

_____

Client /Guardian Signature ***Printed Name*** ***Date***

HUGS' Intake Specialist & Credentials: _____Date: _____

Intake Specialist Printed Name:_____

HUGS' Intake Application

Service Recipient's Registration

Name: (First, Middle, Last) _____

Nick Name: _____ Social Security Number: _____

Date of Birth: _____ Age:_____ Gender: _____ Sexuality: _____

Race/Ethnicity: _____ Religion: _____

Mailing Address: _____ Phone: (Home) _____
_____ (Cell)_____
Zip Code (Work) _____

Email Address: _____

Preferred Method of Contact: _____
Do we have permission to contact you via text message? Y N Voice Message Y N
Do we have permission to contact you via email? Y N

Emergency Contact Name: _____

Relation to Client: _____ Phone: Home_____ Cell _____

Employment Information: I am currently - Employed Unemployed Seeking Employment

If employed, please list the following:
Name of Employer (Company/Business): _____
Date Employed: _____ Current Position/Job Description:_____
Monthly Income: _____

Education: I am currently a student Y N I have completed High School Y N
I have attended college Y N I have a college degree Y N

I am Active Military Y N I am a Veteran Y N

If Client is a Minor (Under the age of 18):
Who has legal custody? Name: _____
Address: _____ Phone: _____
(If Different from Above)

I, the undersigned, have provided accurate registration information (above) to the best of my knowledge. I agree to notify Heads-Up Guidance Services (HUGS) immediately if any changes occur to this information.

Client or Guardian Signature Printed Name Date

Service Recipient's Mental Health History/Self Report

Please describe current difficulties in functioning that should be addressed in counseling sessions.

_____

_____

_____

Were you referred here for services? Y N If yes, who referred you? _____

If no - How did you hear about HUGS? _____

Client's **Family History** of psychiatric/substance use problems? If yes, please describe:

_____

_____

_____

Client's **current** primary physician, psychiatrist, therapist, or other specialists:

_____

_____

_____

Client's **past** physician, psychiatrist, therapist, or other specialists:

_____

_____

Client's **Current Medications** and the conditions for which they are prescribed:

_____

_____

_____

Are you currently experiencing suicidal ideations? Y N

Do you have a history of suicidal ideation? Y N If yes, what year(s)? _____

Number of suicide attempts: _____ Date of attempts: _____

Note the year of that you received any of the following services:

_____Outpatient Therapy _____Inpatient Therapy _____Residential Treatment

_____IOP (Intensive Outpatient Program) _____ Detox

I, the undersigned service recipient, have reported the above information honestly, accurately, and to the best of by ability. I acknowledge that it is my responsibility to notify HUGS immediately upon any change to the above information (i.e. medications, hospitalizations, physicians, etc.)

_____

Service Recipient or Guardian Signature Printed Name Date

Consent for Treatment

Informed Consent for Services

Confidentiality:

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "Medical Records Privacy Law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPA applies to all health care providers, including mental health. Health care providers throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records.

Be informed that the counselors and staff of Heads-Up Guidance Services guard your privacy to the fullest extent. All communications between the client and therapist are confidential and will not be revealed ***unless required by law***, such as in the case of child or elder abuse, or threats of physical harm to the client or others. I understand that it is NOT HUGS' policy to release client progress notes to the client or any public or private entities, even with a signed consent to release information.

Initial: _____

Legal Issues:

HUGS' clinicians do not participate in legal proceedings. If they receive a subpoena to appear in court, the client or the legal representative must agree to pay HUGS $250 per hour plus travel time. Please understand that a subpoena for a counselor to witness in court is always against therapeutic/clinical advisement, as it is likely to harm the client's case. In lieu of a court appearance, the counselor can provide a written Treatment Summary for a fee of $50.

Initial: _____

Electronic Communications:

While your therapist will take reasonable precautions to protect your confidential information, email, texting & social networking are not completely secure methods of communication. Email and other forms of electronic communications may be used for convenience in regards to scheduling, appointment reminders, homework assignments, follow-up care, or information concerning payment status. It is NOT a way of communicating therapeutic information regarding care or emergency treatment.

I acknowledge that if I use electronic mail to initiate contact with my therapist, that he/she and/or his/her representative has my permission to respond via the originally initiated communication (i.e. text, email, etc.)

Initial: _____

Emergencies:

While our clinical staff strives to be available when needed, please note that they are not on call for emergencies. I understand that, if I have an emergency, I should contact the nearest hospital emergency room or dial 911.

Initial: _____

Since Weapons of any kind are NOT allowed in the HUGS' Building, I understand that a special waiver must be signed by law enforcement officers.

Initial: _____

Appointments and Payments

Insurance is not accepted, and clients will be expected to pay for services at the time of their appointments. If clients should choose to submit insurance claims on their own, HUGS will provide receipts for this purpose. Be advised that insurance cannot be billed for late, canceled, or missed appointments. If there is a financial hardship that impacts payment, HUGS' staff is willing to hear concerns and help clients work out an alternative method of payment.

I understand the fee schedule and payment agreement for HUGS' Counseling Services. I know that I will be expected to pay for missed appointments that are not canceled 24 hours in advance, except in the event of an emergency. If my fees are not paid in full for two sessions, I understand that no further sessions will be scheduled until the balance is paid.

Initial: _____

Public Contact

In order to maintain your confidentiality, your therapist will not acknowledge you in the event you encounter him/her in public. This ensures that you will never be put in an awkward position, not knowing how to respond. If you would like to initiate an acknowledgment, your therapist will be delighted to respond. He/she will not be offended if you choose not to do so. While our counselors do not view therapy as shameful or something to be concealed, they understand that discretion is important…and your right to privacy will be respected.

I understand that information about therapy sessions will always be kept confidential, even if I choose to engage in a social conversation in public.

Initial: _____

I agree to have a counseling session recorded for educational/supervision purposes. This would only be done with my written permission, and no names would be revealed to protect my privacy.

Yes No Initial: _____

Legal Consent
To Treatment

Service Recipient's Name: _____Birth Date: _____
Social Security Number: _____Phone: _____
Email: _____

Initial each of the following with your counselor:

____ I have had confidentiality explained clearly to me by a HUGS' Service Provider, and I fully understand that my privacy will be protected and respected by the HUGS' Organization.

___ I have had the "limits of confidentiality" explained to me by a HUGS' Service Provider, and I fully understand that (as mandated reporters) Heads-Up Guidance Services, Inc. is ethically obligated to breach my confidentiality and report to the proper authorities any active intent to harm myself or others, and active/current instances of child abuse or elder neglect.

___ I have been given the contact information for the HUGS' Rights advocate, and I understand that I have an opportunity to schedule a meeting to discuss concerns involving any event in which I feel that my rights may have been violated.

____ I have read the Client Bill of Rights and HUGS' Crisis Procedure.

___ I have had HUGS' program policies, regulations, and expectations explained clearly to me by a HUGS' Service Provider, and I understand the consequences of non-compliance. I agree to abide by/comply with all their policies and safety regulations, and to respect the professional opinions of HUGS' counselors and staff.

____I understand that if there is suspicion or confirmation of intoxication upon arrival for my appointment, I will not be seen, and will be charged for my session.

I have read the above information and voluntarily request counseling services from Heads-Up Guidance Services (HUGS). I agree with their terms and conditions, and I give my formal consent willingly and without force for HUGS to provide any psychotherapy and/or psycho-educational services that their staff recommends and deems necessary for my treatment. I affirm my understanding of "Informed Consent" and "Restricted Confidentiality."

Signature of Client: _____ Date: _____

For Clients Under the Age of 18: I am seeking services for this minor child to engage in a professional relationship with the counseling staff of Heads-Up Guidance Services, and I agree to their terms and conditions.

_____
Signature of Parent/Legal Guardian Printed Name Date

_____
Witness/HUGS' Intake Specialist Signature Printed Name Date

Credit Card Authorization

This form must be filled out even though you may not choose to pay for your appointments with a credit card. (This information will be kept confidential & secure.)

Please provide your credit card information below. This will simplify payment procedures in the event of a missed appointment without notice of cancellation, as well as occasions where an appointment is canceled without 24 hours advanced notice. In either event, your credit card payment will be processed at the end of your scheduled appointment. Your acceptance of this policy ensures your payment will always be up-to-date and will be made in a timely manner.

If you choose to make your payments by Credit Card instead of cash or check, we must charge an additional $2.00 fee per payment for processing costs.

Print Name: _____

Cost of Session: _____ Counselor: _____

Billing Address: _____

_____

(**Must include Zip Code**)

Phone Number: _____

Type of Card: (Circle One): VISA MasterCard

Card #: _____

Expiration Date: _____ CVV : _____ (3 digit # on back of card)

Signature: _____

Please Note: Your signature gives Heads-Up Guidance Services permission to bill your card for services provided and for scheduled appointments not met. This includes "no shows" or cancellations not made within 24 hours of your scheduled appointment time.

Divorce and Custody Cases

HUGS' Counselors Do NOT Evaluate Custody Cases and cannot make any recommendations on custody.

We may elect to see children whose parents are in the process of custody litigation. Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies to which you MUST agree before we enter a counseling relationship.

1. Provided all proceedings have come to a close, we require a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge. We will need to have contact with the parent who has legal custodial decision-making for medical issues before we see the child for counseling, and will need to obtain written consent for the child to participate in counseling from the legal custodian(s). We prefer to have contact with both parents prior to seeing the child.

2. We ask all clients to waive their right to subpoena our counselors to testify in court. This policy is set in order that we can preserve the efficacy and integrity of the therapeutic process and relationship with you and/or your child. It is our experience that a counselor's appearance in court often damages the therapist-client relationship, and it is our ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of our clients. By signing this agreement, you waive the right to subpoena a HUGS' counselor and client records. If you prefer, we will recommend a referral to a therapist(s) who are willing to appear in court.

3. In the event that we are subpoenaed to appear in court despite this waiver- whether we testify or not – we charge the full standard Court Related fee. A retainer of $1,000 is billed and drawn on during the court process. Professional time is billed at $250 an hour. All time dedicated to any court-mandated appearance including but not limited to: preparing documentation, discussions with lawyers and/or a guardian ad litem, affidavits, depositions, wait time spent at the court house, time on the stand, and travel will be billed at $250 per hour. Food and lodging will be billed if expenses are incurred in relationship to the court case.

I understand these policies and I, and any of my representatives now and in the future, hereby waive any and all rights to subpoena Andrea M. Epting or any of HUGS' Clinical Volunteers, Student Interns, Counselors. Clinicians, Supervisors, or Directors, within the HUGS' organization.

Printed Name: _____Signature: _____ Date:____

Printed Name: _____ Signature: _____Date: ____

Authorization for Release of Information

I sign this form voluntarily knowing that I am authorizing the use or disclosure of my individual identifiable health information as described below. I understand that reports and/or medical records to be released may contain information pertaining to social, educational, psychiatric, drug and/or alcohol abuse diagnoses and treatment, and may also contain confidential HIV/AIDS related information. I understand that if the organization authorized to receive the information is not a health plan or health-care provider, the released information may no longer be protected by federal privacy regulations.

Client's Name: _____ SSN: _____ DOB: _____

Organization: Heads -Up Guidance Services 912-417-4320

Collaborating Individual or
Organization_____
(Name) (Telephone) (Email)

I authorize the above listed persons/organizations to give & receive information to each other. Initial: _____

Type of Information that may be released:

_____ Admission Notes	_____Continuing Care Plan	____Court Orders	_____Parole Plan
_____ Assessments	_____ Psychological Evaluation	____Probation Reports	
_____ Educational Evaluations	_____ Psychiatric Evaluation	____ Laboratory Tests/Drug Screens	
_____ School Based Issues	____ Medical Evaluations	____ Police Reports	
_____ Legal Documents	_____ Medical Regimen	____Treatment Plan	
_____ DFCS Investigation	_____Family Relations Report	____ Discharge Summary	
_____ Client Attendance	_____Client Progress	____ Client Billing	

This is needed: ____To provide ongoing care/treatment ____Other: _____

This authorization will expire when this case is closed by Heads-Up Guidance Services, Inc. (HUGS).

I understand that my health-care and payment for my health-care will not be affected by my signing this form. I understand that I may see and copy the information described on this form. I understand that information disclosed in this request about substance abuse treatment is disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless such disclosure is permitted by the written consent of the person to whom it pertains, or as otherwise permitted by (42 CFR Part 2). A general authorization for release of information is not sufficient this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may revoke this authorization at any time by notifying H.U.G.S in writing, but that it will not affect my actions taken before the revocation.

I have read and understand the above statement and do hereby voluntarily consent the disclosure of the information and/or medical records (including alcohol/drug abuse records) to those persons/agencies named above. I hereby release H.U.G.S. of liability arising from the release of this information. If this release concerns a minor, I certify that I am legally authorized to provide consent.

Client or Representative Signature: _____Date: _____
Printed Name: _____ Relationship to Client: _____
Witness: _____ Date:_____