

# Welcome New Client!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies

## **I. Aims and Goals:**

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s). You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

## **II. Appointments:**

Appointments are usually scheduled for 50 minutes. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, your therapist may be reached at 239-273-7587. If you are unable to reach your therapist, you may call your primary care physician or the local emergency room.

## **III. Confidentiality:**

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person; 2) when your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself; 3) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities; 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc.; 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.; 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members about issues discussed.

A clinical chart is maintained describing your condition and your treatment and progress in

treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on site.

**IV. Consent for Treatment:**

I HEREBY VOLUNTARILY CONSENT TO SUCH TREATMENT AS IS DEEMED NECESSARY AND/OR HELPFUL BY GINA KANE COUNSELING, PA. I AM AWARE THAT THE PRACTICE OF COUNSELING IS NOT AN EXACT SCIENCE, AND THAT NO GUARANTEES HAVE BEEN MADE OR IMPLIED TO ME AS A RESULT OF TREATMENT OR ASSESSMENT BY OR THROUGH GINA KANE, MA, NCC, LMHC, PA.

I ALSO UNDERSTAND THAT VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT TO GINA KANE, MA, NCC, LMHC, PA COUNSELING, AND THAT ALL CHARGES INCLUDING NON-COVERED SERVICES, CO-PAYMENTS, AND APPLICABLE DEDUCTIBLES ARE MY FULL RESPONSIBILITY.

By signing below, you are stating that you have read the above and understand the policy statement and that you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient (please print)\_\_\_\_\_

Signature:\_\_\_\_\_

Date:\_\_\_\_\_

Therapist/Witness:\_\_\_\_\_

Notice effective 05/01/2009

Gina Kane, MA, NCC, LMHC, PA  
9470 Corkscrew Palms Circle, Suite 104  
Estero, FL 33923  
(239) 273-7587 FAX: (239) 596-8901

# **Financial Policy**

Thank you for choosing GINA KANE, MA, NCC, LMHC, PA COUNSELING for your professional services. The following is our **FINANCIAL POLICY**, which we require you read, agree to and sign prior to any treatment. This policy is strictly enforced with all patients.

## **PAYMENT TERMS**

Full payment is due at time services are rendered. We accept as payment:

- Cash/Check
- Mastercard/Visa

## **HEALTH INSURANCE TERMS**

GINA KANE, MA, NCC, LMHC, PA COUNSELING is a participating provider for numerous insurance, EAP and managed care programs. Please inquire as to the carriers for which we will accept assignment. It is the responsibility of the patient to verify health insurance coverage with the carrier. Verification of health insurance benefits is **NOT** a guarantee of payment to **GINA KANE, MA, NCC, LMHC, PA COUNSELING**, and all charges including non-covered services, co-payments and applicable deductibles are the patient's full responsibility at the time services are rendered.

## **RETURNED CHECKS**

If a check is returned unpaid or non-sufficient funds, there will be a **\$40.00 returned check fee**. Fees may be recovered using electronic debit through your financial institution. Checks will no longer be accepted once a check is returned unpaid or non-sufficient funds.

## **COLLECTION TERMS**

Any account past due 60 days will be turned over to a collection agency. All applicable collection fees will be the patient's full responsibility. Fees for collection are equal to 50% of the past due amount.

## **CANCELLATION/MISSED APPOINTMENTS**

**As a courtesy, we require 24 hour cancellation notice prior to the scheduled appointment. Individual appointments not canceled within 24 hours will incur a service fee of \$125.00.**

## **ACKNOWLEDGMENT**

Your signature below acknowledges you have read, understood, and agree to the terms of our **FINANCIAL POLICY**.

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**PATIENT/RESPONSIBLE PARTY SIGNATURE**

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**DATE**

Notice effective 12/01/2008

Gina Kane, MA, NCC, LMHC, PA  
9470 Corkscrew Palms Circle, Suite 104  
Estero, FL 33923  
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# PATIENT REGISTRATION

PLEASE PRESENT HEALTH INSURANCE CARD(S) FOR COPYING

NAME \_\_\_\_\_ DATE \_\_\_\_\_

D.O.B. \_\_\_\_\_ S.S.# \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel # \_\_\_\_\_ Work Tel# \_\_\_\_\_

Mobile Tel# \_\_\_\_\_ E-mail \_\_\_\_\_

Send me emails re new useful information on [www.ginakanecounseling.com](http://www.ginakanecounseling.com)

\_\_\_\_\_ Yes \_\_\_\_\_ No

Emergency Contact \_\_\_\_\_ Tel# \_\_\_\_\_

Referred by: (Name) \_\_\_\_\_ Tel# \_\_\_\_\_

## GUARANTOR INFORMATION

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex \_\_\_\_\_

S.S.# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Authorization# \_\_\_\_\_

## CURRENT MEDICATIONS

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## REASONS FOR VISIT

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