April Broussard LCSW

Specific Policies for Treatment

Name _____ Date of Birth _____

Address _____

City/State/Zip_____ Referred by_____

Email Address (which we have permission to send things to) _____

Relational Status _____ Employer _____

Phone #s (with permission to call) (_____)_____ (_____)_____

Emergency Contact Name _____ Relationship to client _____

Contact Information _____

My therapist may speak to the following people regarding my financial information:

_____

My therapist may speak to the following people regarding my medical information (Physician):

_____

Consent to Treatment
Signing this agreement signifies consent for my therapist to provide services to me. I understand that all services are voluntary. I affirm that I am a willing participant. Your care may be discontinued at this office for non-compliance with treatment, missing scheduled appointments, and/or non-payment for services.

Emergencies
In the event of a life threatening emergency, call 911 or immediately proceed to the nearest hospital emergency room. Additionally, mental health professionals are available 24 hours a day, 7 days a week, 365 days a year at the Community Assistance Program at Parthenon Pavilion 615-342-1450, Vanderbilt Respond 615-327-7000, or via the Crisis Hotline 615-244-7444.

Therapy Expectations
I utilize an eclectic approach to therapy which involves active participation on your part both during and between sessions. Participation in therapy will lead to change and change can be uncomfortable at first, so it is important to be aware that a feeling of discomfort or distress can be very normal before improvement is felt. Please feel free to ask questions about your treatment at any time.

By signing below, I am stating that I have read, understand, and agree to the policies on this page.

_____ _____
Patient signature Date

Scheduling & Missed Appointments

As a courtesy, I do not double-book appointments. When you schedule an appointment that time is reserved exclusively for you. It is vital that you keep this appointment time or give ample notice of any need to reschedule. **Cancellations made the business day before our appointment, the day of our appointment or a no-show will be billed to your credit card on file the day of the scheduled appointment.**

This policy protects my practice from loss of availability for my clients in need of services and assists in covering the daily overhead cost of providing my services.

Please be aware that if you have recurrent appointments scheduled and you don't show for one, your future appointments will be cancelled and you will need to call back to reschedule them.

A Functioning Card and number must be provided to be seen.

_____	_____	_____	_____/_____
Credit Card Number	Zip Code	Security Code	Expiration

Confidentiality

This is to inform you that all services received in this office are strictly confidential. Without your written consent for release of information, you participation in services provided at this office will not be confirmed or denied nor will any other information be released. There are certain exceptions to confidentiality.

Exceptions include response to a valid court order, reports of child or dependent adult abuse or neglect, and duty to warn of imminent danger to an identifiable person. Because of the changes made by congress (HIPAA regulations), I am required to inform you of your rights regarding your personal health information and to get your explicit permission regarding your personal health information and to get your explicit permission regarding how your medical information is handled. You may request a copy of the complete policy from me.

***** By signing below I authorize the release of all personal medical records/information maintained by my therapist that relate to service I have received from her/him as needed for my care to my attorney regarding pending or anticipated litigation under a worker's comp, motor vehicle accident, or third party liability claim.

Electronic Mail (email) and Text Messaging
The protection of your Personal Health Information (PHI) is very important and also protected by HIPAA. Neither unencrypted email nor text messaging can be guaranteed to be a secure means of communication. By signing this agreement below you consent to use email, phone, text, and fax as necessary to communicate for care and appointment.

Fees and Payment
Payment of your bill is considered part of your treatment and you are solely responsible to ensuring you pay me for my services. You are responsible for paying any balance, including the current session, at the time of our appointment. Future appointments will not be made with me if your balance becomes excessive. In the unfortunate event that it becomes necessary for your account to be placed with an outside collection service, you are responsible for all collection fees over and above the balance due, including but not limited to a collection fee equal to a percentage of what you owe, attorney fees and court costs.

By signing below, I am stating that I have read, understand, and agree to the policies on this page:

_____	_____
Signature	Date

Payment Contract for Services

Description of Services	**Amount**
Weekday Session (45 min)	$120
Weekend Session (45 min)	$150
Documentation/Report/Letter	$80
Late Cancellation	$80
No Show	Full rate
Late Cancellations and No Shows	● Your credit card on file will be billed for this charge. ● Exceptions include inclement weather when all local school systems are closed for unsafe road conditions/tornadic activity (please call or text 615-680-9822 to confirm)
Telephone Consultation (Attorney/Client/Etc.)	$25/15 Min.
Court	$150/Hr. with an 8 hour minimum per day to be paid in advance. ● In order for me to be involved in a court proceeding I require payment ahead of time as I have to cancel all of my clients on that day.
Returned Check or Credit Card Payment Refusal	$25 in addition to the amount not collected ● In the unfortunate event that it becomes necessary for your account to be placed with an outside collection service, you are responsible for all collection fees over and above the balance due, including but not limited to a collection fee equal to a percentage of what you owe, attorney fees and court costs.

By signing below, I am stating that I have read, understand, and agree to the policies on this page.

_____ _____

Patient signature Date