Paula Rinehart Counseling

Paula Rinehart, LCSW

3900 Barrett Drive

Suite 301A

Raleigh, NC 27609

www.paularinehartcounseling.com

Consent for Services

**Professional Disclosure**

B.S. University of Tennessee, 1973

M.S.W. East Carolina University, 1995

L.C.S.W. NC Certification Board for Social Work, since 2000

**Appointment, Cancellations and Fees**

Sessions will be 50 minutes in length, after the initial visit which is 75 minutes long.

Please provide 24-hour cancellation of an appointment, when necessary. A payment of $75 is charged to cover a missed session, without a 24 hour cancellation. Payment is expected at time of service.

If your counselor is subpoenaed or otherwise required to appear at a deposition, trial or other legal proceeding, you will be charged an hourly rate of $100 for time spent preparing testimony, reports, travel to location, and attendance at proceedings.

**Confidentiality**

The relationship between a counselor and a client is a confidential one. Information will only be released to others with your written permission, with a few exceptions. In special circumstances where the client is a danger to self and/or others, the counselor is required by law to disclose this information to authorities without written consent. Also, in circumstances where child abuse or elder abuse is suspected, the counselor must tell authorities.

**Insurance and Payment**

Services provided are covered by your insurance company, only if you have out-of-network benefits. It is your responsibility to file the receipt of services receipt this office provides with your insurance company in order to collect the applicable reimbursement, which will be mailed directly to you.

Payment is expected at the time of service and payable by cash or check.

**Emergency Procedures**

This office is not staffed with a receptionist or paging system, therefore in case of emergency, we recommend you contact a hospital emergency room, the police, or a primary physician.

**Please read and initial:**

\_\_\_\_\_ I have read the attached Professional Disclosure Statement and hereby consent to services provided by Paula Rinehart, LCSW. I understand the first one or two visits are necessary for adequate evaluation purposes and are not a guarantee of further treatment.

\_\_\_\_\_ I accept the responsibility of payment to Paula Rinehart, LCSW, for all costs, charges, and expenses incurred in these sessions, unless separate arrangements are agreed upon in writing.

\_\_\_\_\_ I understand that it is my responsibility to inform this office of any changes in my insurance, any requirements of preauthorization or ongoing treatment. I understand that out-of-network benefits, if applicable, will be paid directly to me.

\_\_\_\_\_ I acknowledge that I have received and been given the opportunity to read a copy of Paula Rinehart’s Notice of Privacy Practices.

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CLIENT DATE

\_\_\_\_\_\_ I give my permission to be contacted about treatment issues or visit reminders by email or phone.

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CLIENT DATE

My best contact phone number and email address is:

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PHONE number EMAIL Address