O'Connell Case, LCSE, LLC
2501 E. Third Street
Bloomington, IN 47401
812-518-0380

Registration and Consent for Mental Health Services

Client Name: _____ **Date of Birth:** _____

Address: _____ **Email:** _____

City: _____ **Zip Code:** _____

Primary Phone: _____ **Circle Type:** Cell Home Work **Okay to leave message?** Yes No

Secondary Phone: _____ **Circle Type:** Cell Home Work **Okay to leave message?** Yes No

Referred By: _____

Emergency Contact: _____

Phone Number: _____ Relationship **to Client:** _____

Consent for Mental Health Counseling Services

I hereby request mental health services for myself and/or my minor dependent. I, the undersigned, agree and consent to participate in the mental health services offered and provided by Kara Baertsch, LMHC.

Client Signature: _____ Date: _____

Client Representative Signature: _____ Date: _____

If signed by Personal Representative, please state your relationship to Client: _____

Witness Signature: _____ Date: _____

HIPAA Privacy Policy Acknowledgement

I hereby acknowledge that I have received (or was at least offered) a current copy of Kara Baertsch Counseling, LLC's Privacy Notice.

Client or Personal Representative Signature: _____ Date: _____

If signed by Personal Representative, please state your relationship to Client: _____

Financial Policy and Authorization

As a courtesy to clients, we are happy to submit insurance claims directly to the insurance companies with whom we are paneled. It is very important that you check with your insurance provider to determine exactly what mental health services your insurance policy covers and the amount of your deductible, coinsurance, and/or co-pay if applicable, as you are responsible for any services not covered by your plan. If your insurance requires a referral from your primary care provider or physician, that must be done before your initial session.

It is the client's responsibility to pay any deductible, co-payment, or portion of charges as specified by their insurance plan at the time of the visit. Payments can be made by cash, check, or credit/debit card. Clients without insurance are expected to pay for services at the time of the visit unless other arrangements have been made and agreed upon prior to the visit.

We are happy to help you with insurance questions regarding how a claim was filed or any information your insurance carrier might need to process the claim. Specific coverage issues should be directed to your insurance company.

If you are unable to keep your appointment, please cancel by calling 812-518-0380 and leaving a message at least 24 hours in advance. This allows another client to schedule in your place. **Clients who do not cancel 24 hours in advance may be charged a $50 missed appointment fee.** This fee is not billable to insurance and will be your responsibility. Some exceptions are possible for emergency situations. If a client accrues more than 2 late cancellations/no-shows in a 6-month period, that client may be discharged from O'Connell Case, LCSW, LLC and provided with referrals to other providers in the community.

Fees: Initial evaluation $150. Individual 45 min. session $100. Family, couple, or hour-long individual session $125.

Please complete the following information if you are requesting that your insurance or third party payor to be billed for your mental health services. We will also need to make a copy of both sides of your insurance card and will need to update your insurance information any time that information changes. **By requesting that we file with your insurance you are agreeing to pay your full fee and are responsible for any deductible, co-pay, or co-insurance amounts that are not covered by your insurance provider.**

Client Name ___ _____ Date of Birth _____

Client Relationship to the Insured: ___Self _____Child Client's Social Security (SS)#_____

Insured's Name _____ _____ SS#_____ Date of Birth_____

Insured's Address _____ Zip___47421_____

Insurance Co. Name_____ HIP_____ Insurance Co. Phone #: _____

Insurance Co. Address_____ Zip _____

Policy# _____ Group#_____

Is there another Health Benefit Plan? Yes___ No___ (**If yes, please complete an additional form.**)

Your Signature on this form authorizes O'Connell Case, LCSW, LLC or its representative to:

1. **Submit claims to your insurance carrier for services you have received.**
2. **Release all medical/insurance claim information necessary to secure the payment or to certify services.**
3. **Bill the client for all fees not covered by client's insurance company.**

Signature of Client or Parent/Guardian: _____ Date: _____

Client or Parent/Guardian Printed Name: _____

Witness Signature: _____ Date: _____