Dr. Renee' Evans, NCC, LCMHC, CEAP, NCLSC
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Appointments/Cancellations/Confidentiality of Records/Insurance

I. Appointment/Cancellation

A very important part of your therapy/consultation process is accepting responsibility for making and keeping appointments. We make every effort to provide you with your chosen appointment time and we set that time aside for your session. We are reasonable to cancellations that may be unavoidable but, we reserve the right to charge for "no show" appointments and appointments not cancelled within a 24-hour notice.

II. Confidentiality of Records

I understand that all records and information concerning therapy will be kept and maintained in confidence by my therapist, professional associates, and staff of my therapist's office. Information about therapy sessions will not be shared, information about the fact that I or my family members am/are participating in therapy will not be shared without written consent except. I understand that my therapist is required by professional ethics and law to break confidentiality in the event of court order, suspicion of child or elder abuse/neglect, threats of harm to self or others, and threats of harm to me by others. If my therapist believes that there is a need for more intense services that are beyond the regular therapy session, an appropriate referral will be made. In addition, I have reviewed the HIPPA policy.

III. Insurance

If you are not being seen under your EAP benefit, or paying out of pocket, your insurance will be filed. We will provide you with a detailed receipt that you can use to file with your insurance company. Since insurance coverage varies from company to company, your session may not be covered. We encourage you to inquire about reasonable coverage from your company. In the event that your insurance does not cover the cost of your session, you will be responsible for payment of the session. We are dedicated to protecting your confidentiality and privacy. Therefore, we will not answer any questions from or release any information to insurance claims representatives without your written permission.

PATIENT'S (CLIENT) OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Sign & Date_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier of services (mental health counseling services).
Sign & Date _____

Please note that the therapists of Ridgeview Counseling Associates, or R. Evans Professional Development Consultation, Inc., or associates of Regus are not responsible for third party handling of released information. I understand that my therapist or therapist office location is not an emergency or 24-hour service. In an emergency, I agree to contact the local medical emergency service, police, sheriff, or other appropriate agency. Dialing 911 will connect me with emergency services.

I have read or had explained to me the above conditions as well as the Therapy Agreement, and by signing below have agreed to these conditions.

_____ _____

Client Signature & Date Client Signature or Legal Guardian, if minor & Date

_____

Therapist Signature & Date

Updated June, 2020