Michelle Klein Counseling
3943 S. Atherton St
State College, PA. 16801-8308

Individual Informed Consent

I. Your Rights as a Client

- Get respectful treatment that will be helpful to you.
- To choose any provider for your mental health services.
- Have a safe and educated treatment, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist.
- Ask for and get information, before entering therapy about the therapist's qualifications, fees, method of payment, insurance coverage, emergency and crisis policies, and attendance/cancellation policies.
- To participate in or end treatment.
- Know if your therapist will discuss your case with others, for instance a supervisor or consultant.
- Refuse to answer any question or give any information you choose not to answer or give.
- Be informed of your progress.

II. Confidentiality

Information shared with me is confidential except in the following situations:
1. You are an immediate threat to yourself or others.
2. In cases of mandated child or elder abuse reporting.
3. You sign a release of information for an individual or group.
4. Information necessary for consultation with another mental health provider. (This person is required to keep confidentiality and I will not share identifying information such as names.)
5. Information outlined in the HIPAA Notice of Privacy Practice.
6 If required by law such as a court order or subpoena.
7. Information (typically diagnosis and dates of service) necessary to bill your insurance company.

III. Attendance Policy

An appointment is a commitment to my work. A cancelled appointment or no-show interferes with me providing the best, most timely service to my clients. When you must cancel please give me at least 1 full business day notice. If you cancel with less than 24 hours' notice, you will be charged a $45 late cancellation fee, unless in emergency or inclement weather as reflected in a State College Area School District or your home district's cancellation or delay. If you do not call to cancel and miss an appointment there will be a $60 missed appointment fee. I reserve the right to close your case and end services if you miss and/or late cancel three times or more.

IV. Billing Policy
Payment will be required when services are rendered unless otherwise agreed upon. You are ultimately responsible for payment of services. I bill insurance on your behalf and your insurance will deem what you are responsible for, often a deductible and/or co pay.
If you choose not to go through insurance or do not have insurance that covers these services, the agreed upon self-pay rate for the initial evaluation will be

$_____ and subsequent sessions will be at a rate of $_____ each.

V. Financial Agreement
Payments for services provided to you are expected at the time services are rendered. Many, though not all insurance companies do cover a portion of the cost of psychological services. I will follow protocol with your insurance to ensure proper billing of your insurance company. However, you are responsible that your account is paid in full. I strongly recommend that you check with your insurance company to see if you are entitled to receive benefits for counseling services and if there is a co-pay/deductible. Payments returned from your bank due to insufficient funds will be subject to a returned check fee of $30. Overdue accounts (30 days) may be charged a late payment fee. If you are having trouble paying your bill, please speak with me to devise a plan to pay. As a last resort, if your account is overdue 90 days or more it may be turned over to a collection agency or an attorney. I reserve the right to pursue all legal means necessary to secure my interest in being paid for treatment services provided to you. You will be responsible for legal fees and/or collection agency fees if your account becomes delinquent.

VI. Contacting Me/ Clinical Crisis or Emergency
You may call me at (814) 466-9322 and leave a message. I will get back to you within one business day at the most. In the case of a life-threatening clinical emergency if you are unable to reach me please go to the nearest hospital, call 911 or the Centre County 24-hour Can Help line at 1-800-643-5432.

By signing this informed consent, I am acknowledging that I have read this document, have had a chance to ask questions and discuss policies with Michelle M. Klein, LPC and accept these policies as a condition of entering counseling with Michelle M. Klein, LPC.

I realize that starting counseling is a major decision and that it is important for me to make an informed consent to start counseling. I acknowledge that there is some risk involved in counseling including that symptoms might become worse at first. Michelle M. Klein, LPC will do everything within her power and follow ethical guidelines to help alleviate this. The purpose of counseling is to provide a safe, non-judgmental, and supportive environment to learn tools and techniques to address my challenges and help me heal and thrive.

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I understand my rights and responsibilities regarding the counseling relationship. I am aware that I may stop my treatment with this therapist at any time and that I would be responsible to pay for any of the services I have already received. I understand that if payments for services rendered are not paid, my therapist can stop my treatment.

I have had a chance to read and discuss if necessary, the limits to confidentiality including if I am a danger to myself or others, in cases where Michelle M. Klein, LPC is a mandated reporter of suspected child or elder abuse, and if required by law.

In consideration of services rendered, if I use my insurance I hereby transfer and assign Michelle M. Klein, LPC all rights, titles, and interest in any payment due me for said services as provided by all policies of the beneficiary. I hereby authorize Michelle M. Klein, LPC to disclose any information required by said insurance company, its representatives, third party payers, or agencies as may be necessary to verify or process all claims for insurance coverage or third party reimbursement. I agree to pay for all services provided by Michelle M. Klein, LPC, including any deductible, co-insurance payments or charges not covered by my insurance company.

I understand that no insurance company will pay for missed sessions, and I agree to Michelle M. Klein's policy of charging $45 for failure to cancel with a full business day notice and $60 for a missed appointment without cancellation. I accept full responsibility for all payments for services rendered.

I have been offered and (please circle) decline /accept a copy of this consent.

_____

Client (over 14) Date

_____

Parent/Guardian 1 (if applicable) Date

_____

Parent/Guardian 2 (if applicable) Date

_____

Michelle M. Klein, LPC Date