R. JOHN HARTMEYER, JR., LPC, LADC

HARTMEYER COUNSELING SERVICES, LLC
PO BOX 7281 KANSAS CITY, MO 64113 (913) 749-7600

CLIENT INFORMATION

NAME: _____ TODAY'S DATE: _____

HOME ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE #: (_____) _____ - _____

WORK PHONE #: (_____) _____ - _____

EMAIL ADDRESS: _____ RELIGION: _____

SSN: _____ - _____ - _____ Date Of Birth: ____ / _____ / _____

OCCUPATION: _____

EMPLOYER: _____

MARITAL STATUS: _____SPOUSE'S NAME: _____

NAMES & AGES OF CHILDREN OR OTHER PERSON'S IN YOUR HOME:

_____

_____

WHO IS HERE WITH YOU FOR YOUR APPOINTMENT? (PLEASE LIST THEIR NAME AND RELATION TO YOU):

_____

_____

Client's / Guardian's: _____Date: _____
Signature

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CLIENT INFORMATION (CONTINUED)

PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING, AND WHAT THEY ARE FOR:

HOW DID YOU LEARN OF THESE SERVICES?

CLIENT NAME: _____ DOB:_____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

_____

INSURANCE COMPANY PHONE: _____

POLICY #: _____ ID #: _____

I AUTHORIZE THE RELEASE OF ALL CLINICAL AND BILLING INFORMATION TO THE AFOREMENTIONED INSURANCE COMPANY AND ITS AGENTS FOR THE PURPOSE OF PAYMENTS OF BENEFITS.

I AUTHORIZE PAYMENT OF BENEFITS TO JOHN HARTMEYER, LPC/LADC THROUGH HARTMEYER COUNSELING SERVICES, L.L.C. FOR THE SERVICES DESCRIBED ON INSURANCE CLAIM FORM:

_____ (PLEASE INITIAL) *** I UNDERSTAND THAT IF I FAIL TO MEET ANY OF MY FINANCIAL OBLIGATIONS AS SET FORTH IN FEE AGREEMENT, MY UNPAID BALANCE WILL BE CHARGED TO MY CREDIT CARD ON FILE OR SUBMITTED TO A COLLECTION AGENCY SELECTED BY JOHN HARTMEYER, LPC/LADC OF HARTMEYER COUNSELING SERVICES, L.L.C.

Client's /Parent's: _____Date: _____
Or Guardian's Signature

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STATEMENT OF PROFESSIONAL DISCLOSURE FOR

MISSOURI LICENSED PROFESSIONAL COUNSELORS

I providing you this statement to document and inform you about my professional training, orientation/techniques, experience, fee, and credentials. I am licensed to practice my profession by the Missouri Committee for Professional Counselors. My license number is 2005039193 in Missouri. The licensing website is http://www.pr.mo.gov/counselors.asp where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the Professional Counselor Licensing Division listed below for additional information.

Committee for Professional Counselors
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
http://pr.mo.gov/counselors.asp
profcounselor@pr.mo.gov

573.751.0018 Telephone
573.751.0735 Fax
800.735.2966 TTY
800.735.2466 Voice Relay

The above-designated licensee has satisfactorily supplied me with information regarding his practice, licensure and professional development.

_____
Client's or Parent/Guardian's Signature

- -
_____/_____/_____
Client's Name SSN DOB

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CLIENT FEE SCHEDULE & AGREEMENT

Mental health counseling services provided by John Hartmeyer, LPC/LADC through Hartmeyer Counseling Services, LLC is **$120.00** per hour, regardless of your insurance providers' contracted rate with this office. The client understands that payment is *due* at the conclusion of each session, with no exceptions. As a client of Hartmeyer Counseling Services, LLC; the client is responsible for filing their own insurance claims. There is no guarantee that your insurance company will pay for the counseling/therapeutic treatment services that you receive, will receive, or have received at Hartmeyer Counseling Services, LLC. If no payment is made following a session, every session thereafter will require payment to be made prior to services being provided on the day of each session. A returned check will result in a $25.00 service charge and require cash payments to be made for additional sessions prior to services being rendered on or before the day of each additional counseling session.

_____
Initial to Accept This Paragraph

1) By signing below the client understands that counseling services with John Hartmeyer, LPC/LADC through Hartmeyer Counseling Services, LLC are privileged, protected, and compliant with all state and federal laws and statutes including the **Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR, Part 2, 45 CFR Pts 160 and 164 and Missouri State Confidentiality Laws and regulations.** By signing below, the client acknowledges that he/she has been informed of his/her rights and the Federal HIPAA regulations. The client also is acknowledging that he/she has been informed of the following websites for more information about HIPAA: http://aspe.hhs.gov/admnsimp/pl104191.htm and offered to read a copy of their HIPAA rights in written form.

_____
Initial to Accept #1

2) It is the policy of this office that charges for services rendered are due and payable at the end of each session. In the event the client is unable to pay for services in full, the client is to inform John Hartmeyer, LPC/LADC of Hartmeyer Counseling Services, LLC prior to his/her next session so that possible arrangements can be investigated. A payment plan may be negotiated at the consent of both parties. **Unpaid balances are subject to be submitted and collected by any collection agency selected by John Hartmeyer, LPC/LADC through Hartmeyer Counseling Services, LLC. By signing below, I am authorizing John Hartmeyer, LPC/LADC of Hartmeyer Counseling Services, LLC to release any necessary information pertinent to the billing of said counseling services. Additionally/Optionally, John Hartmeyer LPC/LADC of Hartmeyer Counseling Services, LLC is authorized to settle any delinquent balance by charging my credit card(s) previously provided to John Hartmeyer, LPC/LADC and Hartmeyer Counseling Services, LLC.**

_____
Initial to Accept #2

3) If the client has insurance that will assist the client in funding his/her therapy, a receipt from John Hartmeyer, LPC/LADC of Hartmeyer Counseling Services, LLC following payment of service, should be sufficient for filing the claim. This office cannot guarantee the client that his/her insurance company will pay for client's claims or counseling services rendered by John Hartmeyer, LPC/LADC through Hartmeyer Counseling Services, LLC. It is suggested to clients that he or she contact the Customer Relations department of his/her insurance carrier to verify coverage prior to seeking and receiving services from John Hartmeyer, LPC/LADC through Hartmeyer Counseling Services, LLC. In the event that the client's insurance does not reimburse or pay for counseling services by John Hartmeyer, LPC/LADC through Hartmeyer Counseling Services, LLC FOR ANY REASON, the client will be responsible for all fees associated with his or her therapy and the balance will be billed to the credit card on file.

_____
Initial to Accept #3

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4) If the client calls to cancel or reschedule an appointment at least one full business day (Monday-Friday, excluding holidays) in advance, no fees for scheduled, undelivered service(s) will be applied and collected. However, if a client cancels during the 24 hour period just prior to his/her appointment time, a late-cancellation fee of **$25.00** will be billed to the client's credit card on file. In the event that a client fails to attend an appointment and fails to call and cancel/reschedule his/her appointment, the full **$120** fee for the services scheduled will be billed to the client's credit card on file plus processing fee.

_____ Initial to Accept #4

5) Credit Card Payments will incur an additional 5% processing service fee

_____ Initial to Accept #5

6) Any questions about these billing practices and policies or any other office policy or procedure should be discussed directly with John Hartmeyer, LPC/LADC of Hartmeyer Counseling Services, LLC at the beginning of the client's counseling session.

_____ Initial to Accept #6

7) The client has been made aware that payments for counseling services are 1) a therapeutic issue and 2) will be addressed as necessary during their office visits, including scheduling of additional appointments.

_____ Initial to Accept #7

I UNDERSTAND THESE POLICIES AND AGREE TO THE COUNSELING SERVICE FEE OF $120.00 PER HOUR PLUS PROCESSING FEES. FURTHER, I AGREE TO HAVE OUTSTANDING FEES ASSESSED TO MY CREDIT CARD ACCOUNT IN THE EVENT ANY OF THE ABOVE CONDITIONS APPLY. MY RECEIPT WILL BE SENT TO THE EMAIL ADDRESS I HAVE SELECTED BELOW. I AM ACKNOWLEDGING THAT INTERNET CONNECTIONS ARE GENERALLY NOT SECURE AND MY CONFIDENTIALITY COULD BE BREACHED BY CHOOSING TO RECEIVE MY RECEIPT OF PROOF OF PAYMENT BY THIS METHOD. IF I DO NOT WANT RECEIPTS SENT VIA EMAIL, I WILL NOT PROVIDE AN EMAIL ADDRESS BELOW. I UNDERSTAND THAT I MAY CHANGE THIS ELECTION AT ANY TIME BY NOTIFYING OF MY ELECTION HARTMEYER COUNSELING SERVICES LLC IN WRITING. ADDITIONALLY, I AM AWARE THAT I CAN BE PROVIDED A WRITTEN RECEIPT AFTER EACH SESSION. I HAVE HAD THE OPPORTUNITY TO HAVE THESE POLICIES EXPLAINED TO ME VERBALLY AND/OR SHOWN TO ME IN WRITTEN FORM TO MY SATISFACTION.

_____ Initial to Accept Summary:

---------- ---------- ---------- ----------
Credit Card Type Number Sec Code Exp Date

X---------- ----------
Signature of Responsible Adult/Guardian or Client Date

---------- ---------- ----------
Client's Name DOB Client SSN

_____ _____
Address Email Address

_____ _____
City, State, Zip