

Child/Family Registration Form

**FAMILY INFORMATION:**

Child's Name: \_\_\_\_\_ M/F Age: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Child Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Parent's Name (person completing this form): \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Relationship to child (circle one): Mother Father Guardian Other: \_\_\_\_\_

Parent current relationship status: Single\_\_ Married\_\_ Divorced\_\_ Widowed\_\_ Other \_\_\_\_\_

Parent primary address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is it OK for LWC to contact you by regular mail at the above address? Please circle Y/N

Primary contact phone: \_\_\_\_\_ OK to leave message? Y/N

Primary email address: \_\_\_\_\_ OK to contact by email message? Y/N

Additional Parent's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Relationship to child (circle one): Mother Father Step-Parent Other: \_\_\_\_\_

Is this parent living in the home with child? Yes \_\_\_\_\_ No \_\_\_\_\_ If NO, reason: \_\_\_\_\_

Parent address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is it OK for LWC to contact you regular mail at the above address? Please circle Y/N

Primary contact phone: \_\_\_\_\_ OK to leave message? Y/N

Primary email address: \_\_\_\_\_ OK to contact by email message? Y/N

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact information will be kept on file and contacted should LWC be unable to reach you by phone or email.

**ADDITIONAL HOUSEHOLD INFORMATION:**

Additional family members or siblings who are living in the home with child:

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**If parents divorced or child custody agreement in place, please read and complete the information below:**

LWC requires separated or divorced parents to give consent for treatment from **both parents**, regardless of custody agreement, prior to child beginning treatment. A “Parent-Only Consultation” is strongly recommended so each parent may meet with child’s counselor in advance and contribute to a treatment plan.

Additional Family Registration Forms can be found on our website [www.lwc.care](http://www.lwc.care) and emailed or faxed to our office along with a copy of a current driver’s license for this purpose. Please call (817) 238-0106 to schedule a parent-only appointment. If extenuating circumstances apply, please discuss with your child’s counselor at the time of parent intake appointment along with a paper copy of your **Child Custody Agreement**.

**If you have not already provided the biological parent’s information above, please include:**

**Biological Parent’s Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

Relationship to child (circle one): Mother    Father    Other: \_\_\_\_\_

Is parent living in the home with child? Yes \_\_\_\_\_ No \_\_\_\_\_ If NO, reason: \_\_\_\_\_

Date child last had contact with bio parent: \_\_\_\_\_

Does parent exercise regular visitation schedule? Yes \_\_\_ No \_\_\_

Parent address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is it OK for LWC to contact by regular mail at the above address? Please circle Y/N

Primary contact phone: \_\_\_\_\_ OK to leave message? Y/N

Primary email address: \_\_\_\_\_ OK to contact by email message? Y/N

Additional information you wish to provide:

**INSURANCE INFORMATION:**  Current or returning client - check box if no changes to your insurance plan.

Will we be filing under health insurance plan for services rendered today? Yes or No (circle one)

If Yes, please complete insurance information below: Verification of your benefits does NOT guarantee payment by your insurance company. This means ultimately you are responsible for payment of your session(s) if the claim comes back denied for any reason.

**Child Name (minor we will be filing insurance for):** \_\_\_\_\_

Primary Insured Name (person who carries the insurance): \_\_\_\_\_

What is the primary insured relationship to the client? (circle one) Self Spouse Parent Legal Guardian

Primary Insured Date of Birth: \_\_\_/\_\_\_/\_\_\_ Primary Insured SS# \_\_\_\_\_

Primary Insured Employer: \_\_\_\_\_ Primary Insured Address (if different from client): \_\_\_\_\_

Primary Insured City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: \_\_\_\_\_

*Insurance Plan:	ID Number :	Group ID:	HMO/PPO Plan:	Deductible Met: Y/N	Deductible Amount:	Co-pay Amount:

\*We do not accept Medicare, EAP plans or file with secondary insurance plans.

**ADDITIONAL INSURANCE INFORMATION:**

**Do you require insurance to be filed for the parent consultation? Yes/No/Self-Pay (circle one)**

Is your individual insurance plan and coverage the same as listed above for your child: Yes or No (please circle one)

If NO, please complete additional information below: Please note - the initial parent consultation, if child not present, shall be filed under your name and will include an assessment and diagnosis in order to be paid by your insurance plan.

**Adult Name (adult we will be filing insurance for):** \_\_\_\_\_

Primary Insured Name (name of person who carries the insurance): \_\_\_\_\_

What is the primary insured relationship to the client? (circle one) Self Spouse Other: \_\_\_\_\_

Primary Insured Date of Birth: \_\_\_/\_\_\_/\_\_\_ Primary Insured SS# \_\_\_\_\_

Primary Insured Employer: \_\_\_\_\_ Primary Insured Address (if different from client): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone: \_\_\_\_\_

*Insurance Plan:	ID Number:	Group ID:	HMO/PPO Plan:	Deductible Met: Y/N	Deductible Amount:	Co-pay Amount:

\*We do not accept Medicaid, Medicare, EAP plans or file with secondary insurance plans

## Consent for Treatment

### Counseling Fees & Services

\$130.00 Assessment; Follow-up Session	\$65.00 and up, Associate Rate
\$170.00 Assessment, Dr. Jon Shepard	\$65.00 Late Cancellation Fee
\$140.00 Follow-up Session, Dr. Jon Shepard	\$130.00/\$140.00 No-Show Fee
\$225.00 Intake Session; Acute Crisis Management	\$130.00 and up, Summary of Treatment Report
	\$150.00 Attorney Telephone Consultation

### Insurance

Verification of insurance benefits by LWC does not guarantee payment of claims by the insurance company. Please contact the insurance company directly to review insurance benefits and financial responsibility for mental health benefits as plans may vary. The client is responsible for payment in full for any balances on the account as a result of an unpaid or denied claim. LWC does not file with secondary insurance plans or accept employee assistance plans (EAP).

### Associates

An LPC/LMFT Associate holds a provisional Texas State License. This means he/she has met all the educational and competency requirements to be an LPC/LMFT Associate in the state of Texas including holding a Master Degree or higher and is in the process of completing 3,000 professional counseling hours. LPC/LMFT Associates are required to be trained and guided by a state-approved Supervisor. Insurance does not cover Associate counseling sessions.

### Cancellation Policy

LWC has a strict cancellation policy in place. This allows LWC to serve clients who may be waiting to be seen. **Please give us a full 24-hour advance notice** if needing to cancel or reschedule an appointment for any reason. If less than 24-hour notice, the client will be assessed a late cancel fee in the amount of \$65.00 to the credit card kept on file.

### No-Show Policy

If a client simply does not show up for an appointment, the client or the responsible party will be charged the full cost of a session at the time of the missed appointment. \$130.00 Master's Level Clinician; \$140.00 Dr. Jon Shepard; Intern fee \$65.00 and up. Please call between administrative business hours M-F 10:00 AM to 5:00 PM and Saturday 9:00 AM – 2:00 PM (excluding Sundays and Holidays). Please note if a cancellation is made after LWC business hours or on a Sunday or a Holiday immediately prior to a scheduled appointment it is considered a late cancel. All upcoming appointments may be cancelled by LWC written notice until client's outstanding account balance is paid in full.

### Telephone & Emergency Procedures

When calling or emailing, LWC administration staff can usually return a call or message within 24 hours during regular business hours. If the counselor is unavailable in the event of an emergency, it is imperative that the client is aware of resources in the area. If you have a life-threatening emergency, please call 911 or go to your nearest emergency room.

If clients are in need of a follow-up consultation with a counselor, please call to schedule an appointment. Counselors are **not** typically available for free telephone consultations and clients are asked to schedule face-to-face appointments for counseling, parent consultations and case management issues. In the event the client requests a telephone consultation or phoning a third party (attorney, school, medical or other mental health specialist) the fee for such is \$130.00 and up.

*Please Initial*

## Email

Email may compromise client confidentiality. If the client is in a crisis, please do not communicate this to LWC via email because LWC may not see email in a timely manner. Please call LWC for an appointment or if life threatening please go to the nearest emergency room or call 911. If a client still wishes to communicate by email, please email [info@lwc.care](mailto:info@lwc.care) and an administrative staff member will respond directly by email or phone or if requested, make sure the email is directed to the client's counselor ATTN: 'Counselor Name'.

**Appointment Reminders** LWC sends out an automated text and email reminder with client permission to the email address on file approximately 24 hours in advance, however this is a courtesy service and the client is ultimately responsible for attending the scheduled appointment.

## Client Notes

Progress notes are created by the counselor and considered confidential and shall **not** be released to the client or responsible party, including children's progress notes. However, a summary report of treatment history is available upon written request. The cost for a summary report is \$130.00 (Clinician)/\$140.00 (Dr. Shepard). A legal summary is \$150.00 per page. If client requests to review treatment progress, diagnosis, goals, or any other information related to participation in counseling this may be discussed directly with the client's counselor in session.

## Electronic Medical Records

Client records include attendance, payment and insurance information, assessment, progress, diagnosis and treatment goals. All client records are maintained according to state guidelines and are considered the possession of Lake Worth Counseling, PLLC. In the case of the counselor's incapacitation, death, retirement, or termination of practice, LWC shall prepare a plan for the transfer of clients and the dissemination of records to the LWC records custodian. Theranest is the software where client's Electronic Medical Records will be stored and also used to organize client appointment, notes and billing. Client records will be maintained according to the Texas LPC Rules for 6 years after final counseling session. The LMFT Rules require records to be kept for 6 years for adults and 6 years past the age of 18 for a client, who is a minor.

## Telehealth Services

LWC shall utilize Theranest for interactive video which is considered HIPPA compliant and secure. If client is requesting Telehealth services, a separate Telehealth Consent Form will be provided to the client.

## Nature of Counseling

All of the counselors at LWC may have different styles, techniques and personalities but all have one mission; to provide clients with professional, qualified counseling services in a comfortable setting, facilitate personal growth and improve client's overall well-being. You as the client, are freely choosing to enter into treatment and may choose to end treatment at any time. A client's relationship with a counselor is a professional and therapeutic one only. LWC employees shall not participate in social or financial relationships or engage in social media networks with clients. ***If, for whatever reason, a client feels the counselor is just not a good 'fit' after an initial consultation, the client may request to transfer to another one of our professionals.***

## Grievances

LWC encourages clients to discuss any problems they may have directly with the counselor or practice manager. LWC will work with the client respectfully to resolve any issue brought to our attention in order to reach a satisfactory agreement. Clients may submit concerns to [info@lwc.care](mailto:info@lwc.care) ATTN: PRACTICE MANAGER. To report a rules violation by a licensee, contact the appropriate Board: Texas State Board of Examiners of Licensed Professional Counselors; Texas State Board of Examiners of Marriage and Family Therapists; Texas State Board of Social Work Examiners at the following common address: P.O. Box 141369, Austin, TX 78714-1369 (1-800-942-5540).

*Please Initial*

### **Confidentiality**

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: court subpoena, suspected child abuse, abuse of the elderly or disabled, sexual exploitation, criminal prosecutions, child custody case, situations where the counselor has the duty to disclose, or where, in the therapist's judgment it is necessary to warn or disclose.

If the client has any questions regarding confidentiality, please bring them to the attention of the counselor to discuss. By signing this consent form the client is giving consent to the undersigned counselor to share confidential information with all persons mandated by law and the insurance carrier and billing companies responsible for providing mental health care services and payment for those services, and also releasing and holding harmless the counselor from any departure from right of confidentiality that may result.

The client understands that there will be **no recording of the session** and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without written permission, except where disclosure is required by law.

A counselor may converse with other counselors in the LWC group practice for confidential consult in order to provide the best possible treatment for a client. **Acknowledgement of Review of Notice of Privacy Practices & Protected Health Information (PMI)**: Clients are provided online and upon check-in a written copy of the Notice of Privacy Practices.

### **Court Related Issues/Legal Matters & Fees**

Although it is our goal to protect the confidentiality of confidential records, there may be times when disclosure of a client's records or testimony will be compelled by law. If subpoenaed by a judge LWC may be obligated to provide the requested information, whether or not the information is favorable to the undersigned. Should the client involve the counselor in a legal matter, such as a custody issue there may be fees associated with this matter due to the counselor time involved. LWC must be notified at least 14 days in advance of subpoena. All legal fees must be paid in advance or immediately upon request, including subpoena cost (\$1900.00) or the counselor shall deny any participation in court or other legal proceedings. LWC shall ultimately reserve the right to transfer any client case that become litigious.

### **Assignment of Insurance Benefits**

The client authorizes all insurance payments to be made to the designated provider. This order does not relieve the client of obligation to pay such bills if not paid by the insurance company for any reason. It is the client's responsibility to ultimately verify their behavioral health benefits directly with their insurance provider and any cost that may occur. LWC may provide benefit verification as a courtesy only and must have on file the correct insurance information in order to file claims with the insurance company. Denied claims will then become the client's responsibility.

### **Behavioral Health Diagnosis**

If client elects to use insurance, please be mindful that a behavioral health diagnosis must be provided by the counselor. This diagnosis may become a permanent part of the client's medical records. It shall be determined by the mental health provider to provide the appropriate diagnosis and procedure code that will be assigned to client and billed to client's insurance company. Please discuss any client concerns with the counselor. If client chooses not use behavior health benefits for any reason, please let LWC receptionist know at time of check-in.

*Please Initial*



### Procedure Codes

LWC shall designate a procedure code based on type of office visit. Procedure codes may be billed on annual basis based on calendar year or according to client's individual plan. LWC shall bill an initial Acute Intake session (90839) for the client's first visit. Acute procedure code (90839) may also be required for follow-up visits that require in-depth treatment and/or safety plans. Assessment Sessions (90791) are billed up to two (2) follow-up visits (as typically allowed by insurance). Assessment Sessions include counselor conducting an initial evaluation, diagnosis, and treatment plan. Additional visits are considered standard follow-up visits (90837). Psychological testing with Dr. Shepard shall be billed under separate procedure codes. Reimbursement rates will vary depending on the procedure code and client's insurance (if applicable).

### Outstanding Balances

Client agrees to keep ledger account in good standing with LWC at all times in order to ensure an excellent patient /counselor relationship. The client agrees to pay the charges incurred at the posted rates, including applicable late cancel fees or past due balances immediately upon request unless other arrangements have been made in advance. A credit card shall remain on file in order to reserve upcoming appointments and provide guarantee of payment for all outstanding balances. All outstanding balances 15 days past due will be charged to my CC on file and an invoice will be emailed to me. All CC information is stored in electronic and secure file format.

### Credit Card Processing

Signapay is the company that processes the client's credit card information. The credit card holder will receive an email receipt indicating the credit card was used for services, the date it was used and the amount that was charged. Additionally, please be aware that the transaction will appear on the cardholder's credit card bill.

### Invoices & Past Due Accounts

Clients are requested to keep a current email address on file and check their electronic mailbox (including junk mail) for correspondence by LWC. LWC shall make every attempt to contact the client by email and phone, however LWC is not responsible for unread email invoices and any past due balances on the account and shall be charged accordingly. All charges to the client's account will appear on the client's credit card or bank statement. Client agrees to pay the invoice charges, including applicable late cancel fees or past due balances (15 days or more delinquent) or immediately upon request unless other arrangements have been made in advance.

### Telehealth Services

The client may voluntarily agree to receive online therapy services including video, audio or telephone format for an assessment, continued care, treatment, or other services. Additional **Telehealth Consent Form** is required from the client if they wish to utilize such resources. The virtual sessions can only be conducted while the client is within the state of Texas. The virtual sessions must be conducted on a Wi-Fi connection for the best connections and to minimize disruption. LWC strongly suggest that the client only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use "auto-remember" names and passwords. Make sure you have checked your company's policy before using a work computer for personal communication.

### Signed Consent for Treatment at Lake Worth Counseling:

I have read and understood the Fee Policy, HIPPA & Privacy Practices, Limits to Confidentiality, Verification and Assignment of Insurance Benefits, Legal Matters & Fees and Policy and Procedures including the Cancellation Policy and Credit Card Authorization Form. My signature below indicates I give full and informed consent to receive counseling services at Lake Worth Counseling and to the terms set forth in this agreement.

Printed Name \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Child's DOB: \_\_\_\_\_

## Cancellation Policy and CC Authorization Form

In order for us to provide the best therapy for all clients we require a full 24-hour notice if you are unable to keep your scheduled appointment. Your notification allows us to schedule another client who may be waiting to be seen. LWC requires all clients to keep a credit card on file in order to secure appointments. A late cancelation with less than 24-hour notice will incur the following fee:

**Late Cancel Fee - \$65.00**

**No Show Fee – \$130.00 or Full Session Fee**

- I understand that insurance/HSA cards do not cover late cancellation charges.
- It is considered a '**Late Cancel**' if I call after Administrative Office Hours or on a Sunday or Holiday immediately prior to my scheduled appointment.
- Administrative Office Hours: M-F 10:00 AM – 5:00 PM & Saturdays 9:00 AM- 2:00 PM (Closed Sundays & Holidays).
- **Credit Card Authorization:** You hereby authorize us to charge you a Late Cancel Fee according to our policy terms. The late cancel fee will be charged to your credit card at the time of cancellation. All charges to your account will appear on your monthly credit card or bank statement. You agree to pay the charges incurred at the posted rates, including applicable late cancel fees or past due balances more than 15 days delinquent or immediately upon request unless other arrangements have been made in advance.
- My credit card shall remain on file in order to reserve my upcoming appointments and provide guarantee of payment. All CC information is stored in electronic and secure file format. Standard Session Fees: Master's Level Clinician \$130.00; Dr. Jon Shepard \$140.00; Intern Rate \$65.00 and up.

Cardholder Name(as it appears on card) _____			
MC/Visa/Amex Number _____	3 digit security code _____	Exp.Date _____	
Billing Address _____	City _____	State _____	Zip code _____
Authorized Cardholder Signature: _____			Date: _____

**Please Initial Below:**

\_\_\_\_\_(initials) I have read and understand the LWC Late Cancel Policy and agree for my credit card to remain on file to secure my appointments in the event of a 'Late Cancel' or 'No Show'.

\_\_\_\_\_(initials) In the event a session fee, co-payment or co-insurance amount is not collected at the time of visit for myself or a family member such as a child or spouse, I authorize payment by my credit card on file unless other arrangements have been made in advance.

\_\_\_\_\_(initials) I agree to notify LWC if another parent/guardian will be responsible for scheduling or attending appointments with my child, otherwise I assume all financial responsibility including session fees, co-pays and Late Cancel/No-Show Fees.

**If you are unable or unwilling to leave a CC on file please initial below with a deposit:** I do not agree to leave a credit card on file and understand I must pay a cash deposit of \$75.00 in order to secure my appointments with LWC. My deposit shall be refunded to me upon termination of counseling services. \_\_\_\_\_(initials)



## Lake Worth Counseling Policy and Procedures

Name \_\_\_\_\_

Date \_\_\_\_\_

Please read and initial each line below - Thank You

**Counseling Fees & Scheduling:** A therapeutic hour 50 minutes (child session 45 minutes) in order to allow for a brief summary and client scheduling at the end of the hour. Counseling fee per session range from \$65.00 to \$225.00 depending on counselor's licensing and credentials. Balances shall not be carried forward and payment is expected at the time services are rendered. Counseling fees are subject to increase and shall be posted or notified in writing at least 30-days in advance.

**Cancellation & No-Show Policy:** Please call with a full **24 hours-notice** if client needs to cancel or reschedule an appointment for any reason. Your counselor has reserved your appointment time specifically for you and typically has a waiting list for clients to be seen. While LWC understands things come up from time-to-time and we certainly want clients to stay home if ill, a fee of \$65.00 will be charged in order to compensate your counselor for their time. A 'no-show' appointment will result in the full cost of the session. **Client is responsible for calling to cancel or reschedule appointment during regular business hours M-F 10:00 AM to 5:00 PM & Saturdays 9 AM-2 PM. Please note if a cancellation is made after regular business hours or on a Sunday or Holiday immediately prior to scheduled appointment it is considered a 'Late Cancel' and client charged a fee.**

**Emergencies:** Phone calls are returned during regular business hours M-F, 8:30 AM 6:00 PM. However, if you have an urgent or life-threatening emergency please call 911 or go to your nearest emergency room. We do not have after-hours answering service available and are available during regular business hours for administrative duties.

**Client Records:** Client notes are created by the counselor and considered **private and confidential** and shall **not** be released to you, the client under any circumstances - including children's progress notes. If you wish to review your progress, diagnosis, treatment plan, treatment goals, or any other information related to your participation in counseling this shall be discussed directly with you or your child's counselor in session. If a summary report of treatment is required, LWC must have written consent on file to release information to you or another party. The cost for a summary report is \$130.00/\$135.00. Legal summary is \$150.00 per page.

**Notice of Privacy Practices:** Client provided a copy of LWC Notice of Privacy Practices upon check-in. A copy is also available on the website at [www.LWC.Care](http://www.LWC.Care). This notice states how LWC may use and/or disclose client's private health information.

**Insurance:** LWC will file with client's primary insurance plan however if the insurance claim is denied for any reason, client shall agree to pay for the services rendered in full. The insurance plan is a contract between the insured party (client) and the insurance company and ultimately it is up to the client, to verify behavioral health coverage and benefits.

**Appointment Reminders:** Appointment reminders by text and email. LWC will send an automated text/email reminder to the client's phone and email address on file as a courtesy, however the client is ultimately responsible for attending the scheduled appointment time. The counselor may also provide a written appointment reminder. \_\_\_\_\_(initial) I decline automated reminders for privacy reasons.

**Credit Card Information on File:** Clients are required to have a credit card on file in order to secure services. Client agrees to be the guarantor of all appointments scheduled with Lake Worth Counseling, including missed appointment fees, co-pay amounts, deductibles or denied insurance claims. Outstanding balances 15 days past due from invoice will be charged to the CC account on file unless other arrangements have been made in advance. All invoices will be emailed to client's email address kept on file.

**Scheduled Appointments:** Please attend regularly scheduled appointments in order to best achieve therapeutic goals until the termination of services. If three or more consecutive cancelled appointments or a history of frequent cancellations, client may be unable to schedule an appointment with LWC and given an outside referral source.

**Legal Matters & Fees:** Should the client become involved with any legal matters involving CPS, child custody issues, need for testimony or subpoena, the client must notify counselor immediately and shall be responsible for any fees related to matter including summary report fees, professional testimony or subpoena fees. All legal fees must be paid in advance or immediately upon request, including subpoena cost (\$1900.00) or the counselor shall deny any participation in court or other legal proceedings.

**Counselor Consultation:** Telephone consultation \$130.00 per hour. Counselors are not available for free telephone consultations. If preferred, client may email the counselor at [info@lwc.care](mailto:info@lwc.care) a brief 'Read-Only' email. For confidentiality purposes, counselor will not reply directly to the information provided by email and it is not considered confidential communication. If the matter is urgent, please call to move up your appointment in order to be seen promptly. Please call our office during regular business hours M-F 8 AM - 6 PM for assistance.

## INSURANCE DISCLAIMER

**Insurance Patients:** Clients may owe more than what is collected today. Today's estimate is not a guarantee of coverage or the amount the insurance company will pay. If client's insurance company indicates client owes more than what is paid at the time of service or if a service is not covered by the insurance company, Lake Worth Counseling will bill the client for the remaining balance and payment is due immediately upon receipt of invoice. The fee for client visit is an estimate only for anticipated charges taking into consideration insurance coverage, co-payments, deductibles, coinsurance and other information that may affect personal out-of-pocket expense. Please be advised that while Lake Worth Counseling attempts to estimate the cost of the visit as accurately as possible, there may be significant variations between the estimate provided and the actual charges.

Persons with insurance should contact their health insurance benefits administrator for the most accurate information regarding personal liability for anticipated mental health care services.

If LWC is unable to obtain an estimate for the client's insurance benefits or if deductible has not been met to date, client shall be required to pay the full insurance session rate. The front desk will advise the client of the insurance session rate for their specific plan and procedure code at time of service. If deductible has been met after the claim is filed and eligible to receive a refund, Lake Worth Counseling will promptly send client a refund check upon request. Accordingly, LWC makes no representations, express or implied, and disclaims any and all liability, as to the accuracy of this estimate. LWC shall collect the "estimated portion" today and file the claim with the client's insurance company.

Client has read the above disclaimer and understands this is an estimate only and actual balance may be different. Client understands they may contact their insurance company directly for clarification of specific plan coverage and benefits paid and shall not hold LWC responsible for inaccurate benefits or coverage information that was provided in good faith.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_