I authorize this office to leave messages made to my preferred phone number(s), either via voicemail or with a third party, informing me of an upcoming appointment with a named staff member at this named office if I am unavailable to take a call personally. **Preferred Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the providers and staff at Clear Brook Counseling Professionals, LLC to use my preferred e-mail in order to communicate necessary information. **Preferred E-mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that in the case of a clinical emergency that Clear Brook Counseling Professionals, LLC is not a crisis center and that I am to call 911 or proceed to the nearest hospital emergency room for assistance.

I agree to give, **a minimum of** **24-hours’ notice if I cannot make my scheduled appointment and that if I do not give a proper notice, I will be charged a $100.00 late cancellation fee.** Monday appointments must be cancelled Friday by 3:00pm. I acknowledge this fee will not be charged if the office agrees that the circumstances for which I am going to miss my appointment are unavoidable. I acknowledge that my insurance plan will not cover these fees.

I acknowledge that benefits quoted by my insurance company are not a guarantee of payment. I will make any payments that are my responsibility *including* deductibles, co-payments, co-insurance percentages, non-covered services, or products **at the time of service.**

I acknowledge an aging balance of 120 days is in non-payment status. In the event of non-payment, I will be responsible for any collection and/or legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance and will be added to the account if it is turned over to an outside agency. I acknowledge and hereby assume responsibility for paying any charges according to these terms.

I acknowledge that that my counselor does NOT make or take phone calls to or from clients. Administration staff can pass along phone messages to your counselor but cannot guarantee that a phone call will be returned.

I acknowledge that school visits, meetings with lawyers or other third parties in which the patient is not a direct participant, and the preparation of reports for court or other purposes are not billed to or reimbursed by insurance companies. If these types of services are provided *with my prior approval*, I agree to pay the $250 charge *in advance* for any or the anticipated charges.

I authorize Clear Brook Counseling Professionals to charge my credit card being retained on file for any fees not covered by insurance (i.e. Copays, deductibles, **missed appointment fees**).

I acknowledge that a pattern of missed appointments *may result in the termination of services*.

I acknowledge that if my provider does participate in on-line scheduling that I will not schedule out more than 6 weeks in advance. Any appointment scheduled outside of the six weeks can be cancelled without notice.

I understand that if I do not feel that my provider is a good fit, I can talk to the front desk or the provider to find a better fit for me.

**I hereby agree to all the above policies and agreements of Clear Brook Counseling Professionals, LLC.**

**Signature (Parent/Guardian if under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Office Staff \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**