

## Welcome to Awakenings!

Your therapist at Awakenings Center for Intimacy and Sexuality is committed to your emotional health and personal growth. The following information defines the business aspect of our relationship. Please read and sign the following statement on confidentiality and informed consent.

### Confidentiality

Your clinician will not share information with any person without your written consent except as required by law. The clinician is required to release information in the following four situations:

1. When formally ordered to release information by a court of competent jurisdiction;
2. When formally ordered to release information by authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials; by law we cannot reveal when or if we have disclosed such information to the federal government;
3. Child or elder abuse is occurring, or there is reason to suspect that it is occurring; or,
4. A serious threat against yourself, others, or property.

### Appointment times

We will work with you to find an appointment time that meets your needs. If an ideal time is not immediately available, you will be moved to a more convenient time as soon as it can be arranged. When an appointment is made, that time is set aside for you and will not be given to someone else unless you specifically cancel the appointment. Therefore, it is very important that appointments be kept. Please be on time to avoid losing treatment time and have payment ready to avoid using clinical time to conduct business. Our schedules generally will not allow making up time if you are late.

The initial diagnostic session and subsequent sessions are 55 minutes long.

### Therapists and Fees

Our fees vary by therapist; most insurance carriers cover a portion of our fees as an out-of-network provider for mental health.

**Laurie Watson**, LPC (#4162), LMFT (#758), our Center Director, is a Certified Sex Therapist and certified psychodynamic theorist. The initial therapeutic and subsequent sessions last 55 minutes. Fees for therapy with Laurie are \$250 per session.

**Katie Smith, Psy.D** was graduated from the nationally accredited Graduate Clinical Psychology program at Widener University. Katie's 55-minute initial diagnostic and subsequent 55-minute sessions are \$175.

**Caroline Byrd Landen**, LMFT (#1475) was graduated from the nationally accredited Marriage and Family Therapy (MFT) program at the University of Southern Mississippi. Caroline's 55-minute initial diagnostic session is \$180; subsequent 55-minute appointments are \$150.

**Reed Watson**, LMFT (#1929) was graduated from the nationally accredited Marriage and Family Therapy (MFT) program at East Carolina University. Reed's 55-minute initial diagnostic session is \$180; subsequent 55-minute appointments are \$150.

At the Center, these fees are the same for individual or couples sessions. Oftentimes longer sessions allow more in-depth exploration of issues and clients find themselves making quicker progress. You may speak with your therapist about arranging a double session or weekend intensive.

For after-hours and emergency calls, you will be charged *pro rata* in fifteen-minute increments. Our fees increase on January 1 on an every-other-year basis. E-mail communication regarding therapy issues will

be charged similar to a phone consultation with a minimum of one 15-minute increment. Any consultations with other therapists are charged at the same rate as your regular session. Contact by e-mail for making appointments or billing issues is not charged. Therapists do not discuss issues by email.

## **Payment**

Payment in full is due at the time service is rendered. We will provide you a statement at the end of each month that can be submitted to your insurance company for reimbursement. We accept cash, personal checks, and MasterCard/Visa. We do not have the capability of making change; so if you plan to pay by cash, please bring the correct amount. There will be a \$30 service charge for all returned checks. Non-payment of fees can result in termination of professional services and collection activity for any outstanding balances.

## **Cancelled or Missed Appointments**

If an appointment needs to be rescheduled or cancelled, please do so as soon as possible so that the time may be made available to someone else. We charge the full fee for missed appointments, unless notice of cancellation is received 48 hours in advance. Exceptions for emergencies (example: child in hospital, car wreck, death in family) may be made for one session during your treatment. No exceptions are made for: change in business schedule, lack of babysitter, forgotten appointment, or school schedule conflict.

Telephone sessions may be used in lieu of your in-person contact in most situations to keep the continuity of treatment and prevent you from being charged for unused appointment hours. Accessing us by e-mail to inform us of your absence and give us the best phone number to call is often the fastest means of communication. Email may be used for business communication only; all clinical discussion must take place in person.

If you need to cancel after hours or on weekends, please call our voice mail. Voice mail service is available 24 hours a day, 7 days a week when we are not answering the telephone directly. Payments for missed appointments or late cancellations are due with your regular fee at the next visit. Missed appointments or late cancellations are not reimbursable by insurance.

## **Social Media**

Therapy is a professional relationship and Awakenings therapists do not associate with clients using their personal social media.

## **Diagnosis**

Most insurance companies as standard procedure require a diagnosis for the person being treated. This diagnosis will be discussed with you and becomes a permanent part of your health records.

## **Contacting the North Carolina Board of Licensed Professional Counselors**

You may contact the LPC Board to register an ethical or legal complaint by going to the Board's website ([www.ncblpc.org](http://www.ncblpc.org)) and filling out the complaint form and by sending the form to: North Carolina Board of Licensed Professional Counselors, P.O. Box 77819, Greensboro, NC 27417.

## Informed Consent

Please initial each statement and sign below:

1. \_\_\_\_\_ I authorize treatment for myself and/or dependent child.
2. \_\_\_\_\_ I acknowledge that after the initial appointment, sessions are 55-minutes in length unless otherwise agreed-upon, and will start and end at the scheduled times.
3. \_\_\_\_\_ I acknowledge that phone sessions will be billed pro-rata in 15-minute intervals.
4. \_\_\_\_\_ I acknowledge the office policy of providing **48-hour prior notice** when canceling a scheduled appointment and that I am responsible to pay the full fee for any missed appointments that are not so canceled.
5. \_\_\_\_\_ I understand that I am responsible for full payment for each appointment, regardless of what my insurance does or does not cover (please have check ready prior to the appointment).
6. \_\_\_\_\_ I acknowledge that failure to pay my bill may result in my outstanding balance being turned over to a collection agency.
7. \_\_\_\_\_ If on a sliding scale, I acknowledge my agreed-upon fee of: \$ \_\_\_\_\_

I have read this statement and discussed my concerns with my therapist.

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Treating Therapist

## Insurance

Awakenings does not participate with any insurance networks. While we may be able to file electronically with your insurance company as a courtesy to you, we do not guarantee this service. You are completely responsible for tracking all information regarding your benefits for mental health including but not limited to: diagnoses excluded from coverage, needed pre-authorizations, number of sessions covered per fiscal year, if and when reports must be submitted to gain more coverage for sessions. Payment is required in full at each session regardless of what your insurance does or does not cover. We are not responsible for correspondence with your insurance carrier; you may call your insurance carrier or check on-line to discover exactly how they respond to Awakenings' charges.

### **Please choose ONE of the following options:**

\_\_\_\_\_ **NO, I do not want Awakenings to file claims on my behalf with my insurance company.** I understand that I am responsible for notifying my therapist if I would like Awakenings to begin filing claims on my behalf and that I may ask for a billing statement for tax or insurance purposes at any time.

\_\_\_\_\_ **YES, I want Awakenings to file claims on my behalf with my insurance company and understand the following (please initial each):**

- \_\_\_\_\_ **1. AWAKENINGS CANNOT SUBMIT CLAIMS TO TRICARE, MEDICARE, OR MEDICAID.**
- \_\_\_\_\_ 2. I am responsible for understanding, tracking, and resolving any coverage and/or payment issues with my insurance carrier.
- \_\_\_\_\_ 3. Awakenings is an out-of-network practice and cannot guarantee that my insurance company will reimburse me for my sessions.
- \_\_\_\_\_ 4. I authorize the release of medical information, as necessary, to comply with the requirements of my insurance carrier for authorizing payment.

I have read this statement and discussed my concerns with my therapist.

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Treating Therapist

## Contact Information

Name:		Date:	
Address:		Birth date:	
City:		State:	Zip:
Home Phone:		Work Phone:	
Cell Phone:		Email:	
Are you comfortable receiving text messages from your clinician at your cell number? Y / N			
Marital Status:		Length (if married):	
Name of Partner (if any):			
Employer:		Occupation:	
Emergency Contact Person:			Phone:

## Cancellation Policy

We require a full 48 hours notice for cancellation or rescheduling, or the full fee for the appointment will be charged to your credit card. <b>Please initial cancellation policy:</b> _____			
Name on credit card	Credit card number	Expiration Date	3 digit code
Please list name, birth date, and sex of any children and other household members (use back of page for additional space):			
Name / Relation	Birth date / Gender	Lives with you	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
Who referred you to us or how did you find out about Awakenings?			
If you were referred by an individual, may we contact them to thank them for referring you? <input type="checkbox"/> Y <input type="checkbox"/> N			