GREAT LAKES COUNSELING & Wellness Center

432 Woodland Drive
Sandusky, Mi 48471
Phone: 810-878-5050

CLIENT ORIENTATION INFORMATION

Welcome to Great Lakes Counseling and Wellness Center, LLC (GLCWC). Our agency provides mental health counseling to children, adolescents, adults, couples, families, and groups. Please read the following information carefully.

- ❏ Your first appointment, an Intake Session, will be an interview of your history and reasons for seeking services. This is an important first step in determining your treatment path with your therapist. *Most counseling begins with the second session.*
- ❏ Please make sure to inform GLCWC of any changes in your insurance coverage, address, or telephone number. This responsibility is yours.
- ❏ You are responsible for knowing your copay, deductible, or coinsurance; ALL FEES NOT COLLECTED FROM YOUR INSURANCE COMPANY ARE DUE AT TIME OF SERVICE.
- ❏ **If you cannot keep an appointment, you must call at least 24 hours before your scheduled appointment, except in cases of emergencies. Failure to do this will result in a $45.00 cancellation fee. Similarly, failure to show up for a scheduled appointment will result in a $45.00 no show fee.** ***These fees must be paid before another appointment can be scheduled.*
- ❏ **There is a minimum charge of $25.00** for letters written for court appearances, parole/probation officers, and school administrators. There is also a fee to copy charts or complete forms for other organizations. This fee is not billable to insurance therefore is the responsibility of the client or parent/guardian.
- ❏ If it is necessary for a clinician to attend court on your or your dependant's half, **there is a fee of $100 per hour**, including travel time to and from the court house. This fee is not billable to insurance therefore is the responsibility of the client or parent/guardian and must be paid prior to the court date.
- ❏ It's important for your treatment success to use the strategies discussed in therapy outside of your sessions. In doing so, you will be working towards your goals.
- ❏ Smoking, weapons, drugs, and alcohol are forbidden inside GLCWC.
- ❏ GLCWC does not engage in seclusion or restraint.
- ❏ A copy of the HIPAA policy is available upon request.

I have read and understand the contents of the Policies, and have been offered a copy of the Notice of Privacy Practices (HIPAA)

_____ _____

Client Signature (Parent/Guardian if under 18) *Date*

Name:_____D.O.B_____

Protected Health Information Authorization (optional)

Do you give our office permission to discuss your medical information with family members or significant others? Yes ☐ No ☐

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

My signature below authorizes Great Lakes Counseling and Wellness Center, LLC to discuss my PHI with the person or persons lifted above.

_____ _____

Client Signature (Parent/Guardian if under 18) *Date*

GREAT LAKES COUNSELING & Wellness Center

New Client Registration

Date: _____ ***Referred by*** *(if any)**:*** _____

Client's Full Legal Name: _____

Parent/Guardian (if minor): _____

Date of Birth: _____

Home Address: _____

City/State/Zip code: _____

Administrative Sex:

- ☐ M
- ☐ F

Optional

Gender Identity: _____

Sexual Orientation: _____

Phone Number: _____ Home Cell Work

Alternative Phone Number: _____ Home Cell Work

Alternative Phone Number: _____ Home Cell Work

- ☐ Permission to Leave Voice Messages
- ☐ You will receive a reminder call the day(s) before your session(s). **Check this box if you *do not* want a reminder call.**

*If you choose to opt out of a reminder call, please be aware of our policies and cancellation/no show fee.

Email Address: _____

Employment Status:

- ☐ Full Time
- ☐ Part Time
- ☐ Retired
- ☐ Active Military
- ☐ Part Time Student
- ☐ Full Time Student
- ☐ Other: _____

EMERGENCY CONTACT

Name: _____

Phone Number: _____

Relation: _____

Insurance Information

PRIMARY INSURANCE: _____
Member/Enrollee ID #: _____
Group #: _____
Policy Holder's relationship to Client: Self Spouse Parent/Guardian
If Spouse/Parent/Guardian:
Policy Holder Name: _____
Insured Date of Birth: _____
Employer: _____

***SECONDARY* INSURANCE: _____**
Member/Enrollee ID #: _____
Group #: _____
Policy Holder's relationship to Client: Self Spouse Parent/Guardian
If Spouse/Parent/Guardian:
Policy Holder Name: _____
Insured Date of Birth: _____

Account Responsibility

I am responsible for payment to Great Lakes Counseling and Wellness, LLC for all services rendered due at the time of the visit. I also understand that if I suspend or terminate my care and treatment any outstanding balance will be immediately due and payable. If I default on any payment obligation as called for in this agreement, Great Lakes Counseling and Wellness, LLC reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of these actions. There will be no obligation to provide continuing services to any client who names Great Lakes Counseling and Wellness, LLC as a creditor in any bankruptcy filing.

_____
Responsible Party (Print Name)

Insurance Billing

I authorize Great Lakes Counseling and Wellness Center, LLC to release any medical information to our billing company for paper & electronic billing of your insurance. I authorize my insurance company to assign benefits to Great Lakes Counseling and Wellness Center,LLC. I understand that I am responsible for payment for services rendered by Great Lakes Counseling and Wellness Center, LLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify Great Lakes Counseling and Wellness Center, LLC immediately whenever I have changes in my health plan coverage.

_____ _____
Client Signature (Parent/Guardian if under 18) *Date*

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. *However*, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.
*Type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing this form, I am consenting to treatment at Great Lakes Counseling and Wellness Center (GLCWC). I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Signature (Client or Parent/Guardian) *Date*