Integrative Counseling Services, PLLC
Counseling-Consulting-Play Therapy
Jodi Mullen, PhD LMHC NCC RPT-S Director
www.integrativecounseling.us

5 West Cayuga Street Oswego, NY 13126 315.342.9255
6221 Route 31 Suite 110 Cicero, NY 13039 315.699.5123
188 Genesee St Suite 207 Auburn, NY 13021 315.253.4630
104 Cayuga Street Fulton, NY 13069 315.402.2946

Client Information Form

Name _____

Age _____ DOB_____ Grade_____

Address_____

Phone Number_____ Alt. Number_____

Contact Person_____ Relationship_____

Social Security #_____

(If client is a minor, parent/guardian responsible for bills/payments SS#)_____
Parent/guardian DOB_____

Referred By_____ Phone_____

Address_____

Resides in Household with_____

Person Responsible for Payment_____

Presenting Problem_____

_____

_____

Previous Counseling_____

Other Providers Involved_____

ASSIGNMENT OF RELEASE
I, the undersigned, has insurance coverage with _____
(Name of insurance Company)

and assign directly to Integrative Counseling Services, PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the counselor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

_____ _____
Signature of Insured/Legal Guardian Date

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HIPPA ACKNOWLEDGEMENT FORM

I have read and fully understand Integrative Counseling Services, PLLC. information practices. I understand that a representative of Integrative Counseling Services, PLLC. or Play Therapy Clinic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Integrative Counseling Services, PLLC. will consider requests for restriction on a case by case basis, but does not have to agree to request for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted by Integrative Counseling Services, PLLC Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature of patient or patient representative

_____
Date

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Permission Form

Parents or guardians of minor children under the age of 18 must give permission for their child to receive counseling services.

I give permission for (name of child) _____,
(DOB)_____, to receive counseling services from:

_____, under supervising clinician _____ of Integrative Counseling Services or Play Therapy Clinic at Integrative Counseling Services, PLLC.

_____ _____
Printed Name Relationship to Minor Child

_____ _____
Signature of Legal Guardian Date

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Authorization for Release of Confidential Information

I, _____, parent/guardian of_____,
DOB _____ hereby authorize Integrative Counseling Services and/or a Representative of the Play Therapy Clinic to seek/release information to/from:

Oswego City School District
1 Buccaneer Blvd
Oswego, NY 13126

Extent of nature of this information:
(Check all that apply)

YES	NO	
()	()	Attendance
()	()	Recommendations
()	()	Discharge Summary
()	()	Progress in Treatment
()	()	Treatment Plan
()	()	_____

The purpose or need for such disclosure(s) is/are:

()	Confirmation of Attendance	()	Coordination of Treatment
()	Legal Concerns	()	Confirmation of Progress
()	Referral	()	_____

I understand that the confidentiality of my records will be respected to applicable laws and regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken. This consent, unless revoked earlier in writing expires on:

()	90 days following dated signature	()	90 days following treatment
()	Upon completion of treatment	()	_____

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____
Signature of Legal Guardian Date

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Permission to Record Sessions

I give my permission for _____ to videotape
(Counselor)

_____ counseling sessions. This tape
(Client)

will be used only for the purpose of: (check all that apply)

Supervision ( )

Treatment Planning ( )

Education ( )

If requested (yes or no) this tape will be automatically erased immediately after viewing has been completed. I also waive my right to see, copy, or use this tape for any other purpose than its indicated use.

_____ will maintain the above stated rights.
(Counselor)

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Date

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In addition to providing individual counseling for adults, adolescents, and children, we also provide workshops regarding parenting and developmental concerns as well as professional consultation to human services and mental health professionals.

Informed Consent

Mental Health Counseling Relationship
During the time we work together, we will meet weekly, or as scheduled, for sessions lasting approximately 30 minutes for play therapy or 50 minutes for individual adolescent or adult therapy. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions that you arrange with me except in the case of an emergency. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any other way than in the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your goals and concerns. The objective of our counseling relationship is to allow you to work through the problems in your life that bring you to counseling. As such, it is important that you feel comfortable disclosing information to me. In addition, you should feel free to ask questions regarding the course of your therapy if anything is unclear to you.

Effects of Counseling
At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from the counseling process, specific results cannot be guaranteed. Mental Health Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights
Some clients need only a few counseling sessions to achieve their goals; others may require months or years of counseling. As a client (or the parent of a client), you are in complete control and may end our counseling relationship at any time, although we at ICS ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of our counseling techniques or suggestions that you believe might not be helpful. We assure you that our services will be rendered in a professional manner consistent with accepted legal and ethical standards as set by The American Counseling Association & New York State Education Department. If at any time, and for any reason, you are dissatisfied with our services, please let me know or contact Dr. Jodi Mullen, Director.

REFERRALS:
We realize that we are not able to provide appropriate treatment for all of the conditions that clients may have. For this reason, we and/or you may believe that a referral is needed. In that case, we provide you with some alternatives, including programs and/or people who may be able to assist you. A verbal exploration of alternatives to counseling will also be made available to you at your request. You will be responsible for contacting and evaluating those referrals and alternatives.

RECORDS AND CONFIDENTIALITY:
If you are using an insurance company for payment, confidential information will be released to your insurer. All of our communication becomes part of the clinical record. Records are our property, but you have a right to the information within your record. Adult client records are disposed of seven years after the termination of the counseling relationship. Records of minor children are disposed of seven years after the client's eighteenth birthday. Most communications are confidential, but the following limitations and exceptions do exist:

(a) you provide me with your consent to release information;
(b) we have reasonable suspicion that you are a threat to yourself or someone else;
(c) you disclose abuse or neglect of a child, elderly, or disabled person;
(d) you disclose sexual contact with another mental health professional;
(e) we are ordered by the court to disclose information;
(f) you involve us in a lawsuit and we need to release specific information in order to receive compensation for services rendered;
(g) we are otherwise required by law to release information.

If I see you in public, I will protect your confidentiality by acknowledging you only if you approach first.
*Requests for records will be met within 10 business days
- Our counselors prefer to provide treatment summaries to clearly and concisely discuss the client's treatment. Play therapy notes may only be interpreted by certified Child-Centered Play Therapists or Registered Play Therapists.

PARENTS OF MINOR CLIENTS: It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint. Because the therapeutic relationship is vital to change and support, we discourage parents to include the counselor in any court proceedings involving the children as clients. If you make the decision to involve your child's counselor in such proceedings, please be advised that you will be billed at an hourly rate proportionate to the self pay rate for counseling (see attached fee schedule) for the counselor's preparation and court appearance.

DIAGNOSES:
It may be required of me to provide a diagnosis to a third party, such as an insurance agency, in order to be paid. Diagnoses are technical terms for the problems you have come to counseling to address and can be further explained in the book I will use as a reference when giving them: the DSM-5. If at any time you wish to see the DSM-5, I have a copy in the office that you may look at.

By your signature below, you are indicating that you read and understood this statement, and that any questions you had about this statement were answered to your satisfaction

_____ _____
Printed Name of Client Date

_____ _____
Signature of Client or Legal Guardian Date

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ICS Policy for Oswego City Schools: Insurance

Client Name: _____ Date: _____

- In order to begin services with an ICS counselor, the child must be covered under a participating insurance.

- If you have multiple insurances, the primary insurance must be one that we participate with. We cannot bill a secondary insurance.

- It is important to know if your insurance company has a date where you must recertify, otherwise you might lose insurance, and these sessions will not be covered. You will then be liable to pay for these sessions.

- If your child does lose insurance, please notify the ICS office or the counselor immediately. This will ensure you do not end up owing out of pocket for any sessions that were not covered.

- ICS does not participate with Medicaid, so as soon as the child starts to receive SSI Benefits, their sessions will no longer be covered.

- If the child loses insurance, you have two weeks to contact ICS and set up a payment arrangement, otherwise the child will no longer be eligible for services. Your child will be discharged and you will be billed.

- If there is a period where the insurance lapses and you have already accrued a back balance from uncovered sessions, ICS will waive payments from two sessions, per child, per year, as a courtesy. You will be responsible for all other fees associated with the lapse in insurance.

I, _____, have read the above statements and understand that if there are any changes in insurance after the original intake, I am responsible to contact the counselor or the ICS office directly to discuss other options for payment. I understand that if my child receives SSI Benefits, that their insurance will no longer pay for benefits. I understand that if the insurance is not recertified that the child will lose coverage and I will be responsible to pay for those sessions. I understand that once the child loses insurance, I have two weeks to set up a payment arrangement with ICS, otherwise the child will be discharged from services.

Print Name: _____
Signature: _____
Date: _____

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Oswego City Schools No-Show Policy

If a child misses three (3) consecutive sessions in a row, he or she will be discharged from counseling. The reasons for missing sessions include but are not limited to lost insurance and school absences. In order to get them back in to receive services, a brand new intake will need to be created, insurance must be approved, and he or she will remain on the wait list until there is an available slot.

I, _____ (parent/guardian), understand that I am responsible for making sure my child has active insurance and does not miss three consecutive counseling sessions. I understand that my child may temporarily lose services if we do not adhere to this policy.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

Date: _____

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FEES

Integrative Counseling Services, PLLC provides a variety of clinical services, including play therapy, child, adolescent, and adult individual counseling, couples and family counseling, and assessments and evaluations, as described below. Please read the descriptions carefully and refer to the Service Fees chart, attached.

Self pay rates: If you choose to see one of our counselors, and do not have insurance coverage, our rates are as follows: In return for a fee of $50.00 ($90.00 initial session) per play therapy session or $60.00 ($100.00 initial session) PhD and PsyD Level, $85.00 ($100.00 initial session) Master's level per individual adult or adolescent session, we agree to provide counseling services for you or your minor child. If the fee is a hardship for you, please let us know. Cash, personal checks, and Visa or MasterCard payments are acceptable. The fee for each session will be due and must be paid at each session.

Insurance: Your Primary Insurance is billed by Integrative Counseling Services, PLLC as a courtesy to our clients. Your insurance benefits will be verified prior to your first appointment to be certain coverage is available and that your provider is able to bill for services under your contract. Insurance policies are contracts between you (or your employer) and the insurance company, **therefore, it is your responsibility to understand your insurance policy requirements and limitations.** Please take the time to verify your insurance benefits. We cannot guarantee payment of claims. If your insurance lapses or you do not have active coverage, you are responsible for all charges incurred while you are without insurance.

Charges not covered by insurance companies:
Many health plans and insurance companies may not cover some services and do not provide benefits for the services. Services which may not be covered by your insurance company include, but are not limited to court appearances/depositions, telephone consultations, written consultations and treatment summaries, as described below.

Telephone Consultations (also includes email consultations): Time spent with you on the telephone by your mental health professional other than for appointment information may be charged at a prorated hourly rate. Other telephone consultations on your behalf, such as consultations with other therapists, psychologists, school officials, will be billed at a rate proportionate to the rate for counseling.

Written communications to you or on your behalf will also be billed at a rate proportionate to the rate for counseling. This includes treatment summaries.

Request for Clinical Records: $.75 per page plus postage

Psychological Testing: Your counselor may suggest psychological testing as a brief and efficient method of gaining information about important aspects of your personality and/or current psychological status. A list of evaluations and fees is attached.

COURT ACTION/LEGAL FEES:

Legal Proceedings: If you request that your therapist meet with your attorney, and/or make a court appearance on your behalf (or if an appearance is required by subpoena) your therapist may be required to clear the entire appointment calendar for that day or for a block of time. To accommodate your need for the therapist's appearance and testimony, and to adequately prepare and review any necessary documents and records for either a consultation or an appearance, the following hourly fees may apply. **These are items not normally covered under private insurance:**

Court Appearances: $500 flat-rate fee for attending court or being on-call

Preparation of forms and reports: PhD Level Counselor - $120 per hour; Master's Level Counselor - $90.00 per hour

Request for Clinical Records: $.75 per page plus postage

Telephone, written, or email consultations regarding court proceedings: PhD Level Counselor - $120.00 per hour; Master's Level Counselor - $90.00 per hour.

By your signature below, you are indicating that you read and understood this statement, as well as the Service Fee statement that you are in agreement of Integrative Counseling Services, PLLC fees, and that any questions you had about our fees were answered to your satisfaction

_____ _____

Printed Name of Client Date

_____ _____

Signature of Client or Legal Guardian Date

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ICS Court Appearance Policy

Effective 12/01/2017

1. Please be advised that counselors do not appear in court for their clients regarding custody, visitation, and instances where the counselor/client relationship could be damaged.
2. A counselor appearing in court is often damaging for the therapeutic relationship and should be avoided.
3. If a counselor is subpoenaed for court, Integrative Counseling Services, PLLC requires a $500 flat-rate fee for attending court or being on-call. This must be paid prior to the on-call date. If this fee is not paid, you may be subject to collections.
4. Counselors will provide a treatment summary for the court, upon request. You must request this paperwork with at least one-week notice.

I, _____ (parent/guardian), understand ICS's Court Appearance Policy as written above, and understand that I am responsible to relay that information to my attorney and any other applicable personnel. I also understand I am responsible to pay the $500 fee upfront, if the counselor is subpoenaed for court for (child's name) _____.

Signed:

_____

Date: _____

_____ (client) received this documentation on _____ (date).

Counselor Signature_____ Staff Witness Signature _____

Integrative Counseling Services, PLLC
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{Service Fees}

Services Offered	PhD/PsyD Level Counselor	Master's Level Counselor
SELF PAY RATES: **Play Therapy** Initial Session Subsequent Sessions	 $100.00 $60.00	 $90.00 $50.00
Adolescent Initial Session Subsequent Sessions	 $150.00 $120.00	 $100.00 $85.00
Adult Initial Session Subsequent Sessions	 $150.00 $120.00	 $100.00 $85.00
Couple/Family Initial Session Subsequent Sessions (60 Min) Subsequent Sessions (90 Min)	 $150.00 $120.00 $150.00	 $150.00 $120.00 $150.00
Telephone conversations and written communications to you or on your behalf	Will be billed at a rate proportionate to the rate for counseling.	Will be billed at a rate proportionate to the rate for counseling.
BioPsychosocial Evaluations	$175.00	$175.00
Request for Clinical Records	$ .75+postage	$ .75+postage
Psychological Evaluations	Fees based on the number and nature of tests given	Charges are based on the time for administering the tests and interpreting the test results, necessary and appropriate interviews and preparing a report.
Coaching Services	Please call for an explanation of types of coaching services available and fees	Please call for an explanation of types of coaching services available and fees
COURT ACTION/LEGAL FEES: **Court Appearances** **Phone calls/letters/reports**	$500 flat-rate fee for counselors being on call or having to appear in court. PhD Level Counselor - $120 per hour for additional preparation, phone calls, and/or reports/notes.	$500 flat-rate fee for counselors being on call or having to appear in court. Master's Level Counselor - $90.00 per hour for additional preparation, phone calls, or reports/notes.