

**Main Street Counseling, LLC**  
**1284 Jungerman Road**  
**Suite B**  
**St. Peters, MO 63376**

**CLIENT INFORMATION -- FINANCIAL RESPONSIBILITY – INFORMED CONSENT**

File: client consent for treatment

1. Client Name \_\_\_\_\_ Home Tel: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_  
DOB: \_\_\_\_\_ age \_\_\_\_\_ M \_\_\_ F \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Other \_\_\_\_\_  
Full time student \_\_\_yes \_\_\_no Employed \_\_\_ No \_\_\_ Yes Client's School/Employer \_\_\_\_\_  
Tel Wk: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_  
Position /grade \_\_\_\_\_ It is okay to leave messages at my \_\_\_ home \_\_\_ work  
Social Security # \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Tel: \_\_\_\_\_

2. Primary Doctor \_\_\_\_\_ Address \_\_\_\_\_ Tel: \_\_\_\_\_  
Referred By: \_\_\_\_\_

3. Method of payment: \_\_\_ Self Pay \_\_\_ Insurance \_\_\_ Medicaid \_\_\_ CTS \_\_\_ other \_\_\_\_\_

4. Insurance Company \_\_\_\_\_ Tel : \_\_\_\_\_  
Address back of card \_\_\_\_\_ Policy # \_\_\_\_\_  
Group # \_\_\_\_\_ ID# \_\_\_\_\_ Co-pay amount \_\_\_\_\_ Deductible Amount \_\_\_\_\_ Medicaid# \_\_\_\_\_

5. Insured Information If different than client: Name \_\_\_\_\_ DOB: \_\_\_\_\_ Tel # hm: \_\_\_\_\_  
SS#: \_\_\_\_\_ Relationship to client \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Tel Wrk: \_\_\_\_\_

**FINANCIAL RESPONSIBILITY:** In consideration for services rendered to the client herein, the undersigned responsible party agrees to pay Main Street Counseling, LLC for services rendered to the above client. A client eligible for services provided by companies, preferred provider organizations, health maintenance organizations are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirement including by not limited to pre-certifications, co-payments, and deductibles. There are conditions of payment of benefits by companies, preferred provider and health maintenance organizations. By signing this form, which includes a statement about financial responsibility, I, as the client, and/or guardian of the client agree that I am responsible for payment of services rendered in any case in which payment is denied by companies, preferred providers, and health maintenance organizations because of a failure to comply with such coverage requirement or for any other reason. ALL CO-PAYMENTS AND DEDUCTIBLES ARE THE RESPONSIBILITY OF THE CLIENT AND ARE DUE AND PAYABLE AT THE TIME OF SERVICES.

**FEE FOR SERVICES SCHEDULE:** Office: \$90.00 Letters/ reports: \$35 Copies per page: .35 cents Court involvement and consultation: 1 hour \$180 (Port to port). All telephone calls over 15 minutes in length will be charged to you at the rate of \$90 an hour and will be billed in 15 minute increments.

**FEES AND MISSED APPOINTMENTS:** It is your responsibility to notify Main Street Counseling, LLC at least 24 hours in advance of any scheduled appointment, which you will be unable to keep. A \$25 missed appointment fee will be charged with less than 24 hours notice, except in the event of an emergency. Two missed appointments without a 24 hour notice, except in the event of an emergency will result in a cancellation of services. Please notify Main Street Counseling, LLC if you are no longer interested in therapy services. It is your right to end services at any time, however "dropping out" without notifying is an inconvenience and may delay services to someone else.

**ASSIGNMENT OF COUNSELING BENEFITS:** I hereby assign payment of insurance benefits, including but not limited to Medicaid, health maintenance organizations or preferred provider organizations payable to me to be paid directly to Main Street Counseling, LLC for treatment charges. I request that payment of benefits be paid directly to Main Street Counseling, LLC on my behalf.

**RELEASE OF INFORMATION** I also authorize and direct any holder of medical and other information about me as it pertains to my health care to release all needed information to determine benefits payable and to process my claims.

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**INFORMED CONSENT FOR TREATMENT**

I \_\_\_\_\_ (client name) request treatment by Main Street Counseling, LLC. I consent to routine assessment evaluations, and counseling as deemed necessary. I understand that Main Street Counseling, LLC makes no guarantees as to the results of treatment or evaluation. The therapy process is one in which you seek to understand yourself, your feelings, and your concerns more clearly, and perhaps, to make some changes in your life as a result of what you have learned. My role in this process is to help you gain a different perspective on yourself, your feelings, and your life. I will seek, first, to get to know you so that I can better understand your concerns. You will aid me in this process by being open and honest in our sessions and providing as much information as you can concerning the issues that trouble you. Occasionally, I may say things that you find difficult to hear. Your therapy goals will best be achieved if you can remain open to emotions, insights, and ideas, which may be different than what you have experienced before. Because the therapy process sometimes involves an examination of aspects of yourself, which have previously remained hidden, you may be surprised by the intensity of new emotions. Be assured that this is a normal part of the healing and change which occurs through therapy.

All of our sessions are confidential. The ethics of my profession prevent me from discussing you or your situation outside of our sessions, with the following exceptions: 1) if someone is in danger of being harmed (you or someone else), 2) if I become aware of the existence of physical or sexual abuse of a child or an elderly adult, 3) if I or my records are subpoenaed by a judge, and 4) if you give me written permission to release your records to another party, such as DFS, the Juvenile Office, or another therapist with whom you have worked. To maintain the highest quality of service for my clients, I may, at times, consult with a colleague. All sessions are private and no video or audio taping will be allowed unless written all parties give written consent.

You have many rights as a client under my care. Several of them have been granted to you by the information contained in this document. Specifically, you have the right to: (1) have knowledge of my qualifications and training, (2) be fully informed regarding the conditions under which services will be provided to you, (3) discuss your therapy with anyone you choose, (4) request an explanation of any procedure or form of therapy used in your treatment, (5) review your file with me and have summaries of your file released to other professionals with your written request, (6) end therapy at any time, hopefully after you have discussed your reasons with me, (7) ask me questions. If there is something about which you are confused, please feel free to ask me questions and expect an explanation that you understand and that respects your rights.

If you have any questions or concerns about the information contained in this document, please discuss them with me at your earliest convenience.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** You are hereby notified that you may review the NOTICE OF PRIVACY PRACTICES, which explains when, where and why your confidential health information might be used or shared. I understand that Main Street Counseling, LLC may share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for any other issues that concerns operations and responsibilities.

\_\_\_\_\_ Yes I choose to receive a copy of the NOTICE OF PRIVACY PRACTICES

\_\_\_\_\_ No I have decided to not receive a copy of the NOTICE OF PRIVACY PRACTICES

THE UNDERSIGNED CERTIFY THEY HAVE READ THE STATEMENTS SET FORTH, HAVE COMPLETED THE INFORMATION CORRECTLY, AND ACCEPT THE TERMS HERIN:

\_\_\_\_\_  
Client Signature /Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

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**COMPLETE ONLY WHEN CLIENT IS MINOR**

With my signature I also verify that I am the CUSTODIAN of \_\_\_\_\_ (minor) and that I give permission for said minor to participate in counseling with Main Street Counseling, LLC.

LEGAL Custodian \_\_\_\_\_ PHYSICAL custodian \_\_\_\_\_

If you have a custody agreement for client you will be required to provide a copy of the legal custody agreement to this counselor. I.e. Divorcee papers, etc.

Responsible Party Signature \_\_\_\_\_ Dated: \_\_\_\_\_

PRINT - Guardian Name \_\_\_\_\_ Relationship to Minor \_\_\_\_\_ Dated \_\_\_\_\_