Welcome!
Brenda Hollingsworth, MSW, LICSW
Licensed Clinical Social Worker and Counselor

Client Information

Date________________ Referred by: __________________________________

Name:____
First Middle Last

Address:____

City:_________________ State:__________ Zip_________________

Date of Birth:_________________ Age: ____________ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Dating ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Cohabiting

Home Phone (___)_______________

Cell Phone (___)_______________

I would like to receive appointment reminders by:

☐ Voice Mail - _(____)_______________

☐ Text Message

Employer_____________________________________ Work Phone_________________

If Student, Name of School__________________________________ ☐ FT ☐ PT

Spouse, Significant other, or Parent's Name:_____________________________________

Person to contact in case of emergency____

Phone______________________________

Email address ____

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication, for example for appointment reminders, or to make changes in appointments. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your therapist, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your therapist.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with your therapist about ways to keep your communications safe and confidential.

This Consent is Optional

– Please consider carefully before signing –

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Brenda Hollingsworth LICSW to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Other information that I initiate a request for

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

____ ____________________

Client Signature Date

Please do not use E-mail, Texting or Faxes for emergencies.

Please bring insurance cards to your first session and give to therapist to be copied.

Have you contacted your insurance company to verify mental health benefits? Y N

Do you need prior authorization? Y N # of sessions allowed? ______

Do you have a deductible? Y N

If yes, amount? ________ How much is left to pay? _________

Do you have a co-pay or co-insurance? Y N If yes, what amount? _________

Primary Insured (if other than Client)

Name of Insured ____ DOB_________________

Relationship to Client ____________________________

Name of Employer:________________________________ Work Phone: (____)_____________

Address of Employer:____

City __________________ State: _____ Zip ____________

Insurance Company____

Grp #_________________________ ID#____________________________

Ins Co Address:____

Ins Co. Phone:_________________________________

Responsible Party if other than Self

Relationship to Client: ☐ Spouse ☐ Parent ☐ Other ________

Name:____

Address:____

City:______________________ State:_______ Zip:____________ Phone: (____)_____________

Employer____ Work Phone (____)_____________

Clinical Services and Fee Agreement

Brenda Hollingsworth, MSW, LICSW of Freedom Counseling LLC is a private, clinical service provider. Insurance will be billed, if information is provided. Otherwise, payment is expected at the time of service. Payment can be made in the form of cash, check, or credit card. Co-pays are due at the time of each appointment. Please understand that when you make an appointment, I am reserving that time for you. If you are late, there may or may not be a possibility of extending your session to give you your full time. If you miss an appointment, that is time that could have been spent with another client, therefore it is necessary for me to charge for missed appointments. There will be no charge if notice is given 24 hours before the session, or if you are ill or have an emergency.

My individual counseling fee is $160.00 for intake assessment, $120.00 for a 55 minute session and $95.00 for a 40 minute session. I provide pro-bono sessions at $85 for those with no insurance.

Auxiliary Service Fees

The auxiliary service fees are listed below. All clients are personally responsible for these charges in full.

- Preparation of legal documents and special reports………...........clinical hourly fee.
- Attendance of therapist at meetings…………………………........clinical hourly fee.
- Attendance of therapist at court proceedings……………..……..clinical hourly fee.
- Phone calls over 15 minutes………………………………………clinical hourly fee.

Terms and Conditions

I understand and agree that:

- The clinical fee or co-pay is due and payable by me at the time services are rendered.
- If the account should become delinquent, it will be subject to collection with any costs of fees resulting there to be paid by me, including, but not limited to, court costs and attorney fees.
- If my personal check is returned for non-sufficient funds (NSF), a service fee of $35.00 will be added to the face value of the NSF check.
- Brenda Hollingsworth, MSW, LICSW reserves the right to charge me my full clinical fee for any session that I cancel with less than 24 hours' notice, unless ill or have an emergency or prior arrangements have been made.

Release of Benefits

I authorize my insurance benefits to be paid directly to Brenda Hollingsworth, MSW, LICSW. I understand that I am financially responsible for non-covered services. I also authorize the release of any medical information necessary for processing.

______________________________ ______________

Client Signature Date

______________________________ ______________

Parent/Legal Guardian Date

Acknowledgement of Notice of Privacy Practices:

My signature indicates that I have had the opportunity to read the attached HIPAA Notice of Privacy Practices and had an opportunity to ask any questions I may have.

Complaint/Grievance Process:

I have had the opportunity to read the attached grievance process and have asked any questions I may have.

Client Rights, Responsibility and Confidentiality:

My signature attests that I have read, and fully understand the attached statement of my rights as a client, as well as my responsibilities. Additionally I am aware of the limits of confidentiality.

Consent for Treatment:

By signing below, you indicate that you have read this disclosure, that your questions have been answered and that you understand the above information. Your signature also indicates that you are consenting to receive counseling services through Freedom Counseling LLC/Brenda Hollingsworth, MSW, LICSW. No guarantees have been given by Freedom Counseling/Brenda Hollingsworth, MSW, LICSW as to the results that may be obtained. I indemnify and hold Freedom Counseling LLC/Brenda Hollingsworth, MSW, LICSW harmless from any and all claims arising directly or indirectly from the services rendered by her under this agreement. Such indemnification shall include attorney fees and costs.

____

Client Signature Date

____

Parent/Guardian signature (if applicable) Date