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DISCLOSURES & INFORMED CONSENT AGREEMENT

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how therapeutic relationships will work, and what you and your therapist can expect. This consent will provide a clear framework for your work together with your therapist. Feel free to discuss any of this with your therapist. Please read and indicate that you have reviewed this information and agree to it by putting your initials and signature where indicated.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. Your therapist cannot promise that your behavior or circumstance will change. They can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. When doing relationship or family counseling, sometimes secrets can interfere with treatment when counseling involves more than one person. If a "secret" is disclosed that is harmful or interferes with the goals of counseling, your therapist will bring the issue up with you. In these cases, what you share in individual sessions may be shared in later meetings with your partner or family. Your therapist will help you determine the best ways to share this information.

Electronic Records
We utilize a HIPAA-compliant electronic healthcare record (EHR) system in order to protect your confidentiality and privacy. The EHR provider has a Business Associate Agreement (BAA) with us that complies with HIPAA standards.

Confidentiality & Data Privacy Policy (HIPAA)
This notice describes how your health information may be used and disclosed and how you can access this information. Please review this and all other policies carefully. We are committed to protecting our clients' privacy and confidentiality. A state and federal law, the Health Insurance Portability and Accountability Act (HIPAA) went into effect on April 14, 2003 and requires us to inform you of this policy. HIPAA requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information to obtain payment of the services you receive (e.g. we can send information as requested by your health insurance plan). We may use or disclose your health information for our normal healthcare operations (e.g. staff who complete scheduling, training of staff who have signed confidentiality agreements, etc.). We may share your medical information with our business associates, such as a billing service, administrative staff, etc. To protect your privacy and confidentiality we have a written contract with each business associate requiring them to protect your privacy. We may consult with other licensed professionals in counseling as necessary, protecting your confidential information, to gain guidance for your treatment. We may use your information to contact you (e.g. mailings). We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine, or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. Finally, we may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner(s). Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing

we not use or disclose your health information as described above. We will let you know if we can fulfill your request. The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person or vulnerable adult who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. If an investigation or disciplinary proceeding is mandated by the licensing board and your information is involved in those proceedings.
9. To defend Eclipse Counseling LLC or our therapist(s) in a legal action or other proceeding brought by you against our clinic or service providers.
10. When required by the Secretary of the Department of Health and Human Services in an investigation to determine my compliance with the privacy rules.
11. To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on our behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions.

Minors: If you are a minor, you have a limited right to privacy in that your parents/legal guardians may have access to your records. However, if the therapist believes sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. However, Eclipse Counseling and group therapists are not responsible for any breaches of confidentiality by group members.

Acknowledgement in Public Setting: If you see your therapist outside of the therapy office, they will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to them, and they do not wish to jeopardize your privacy. However, if you acknowledge them first, they may speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use the address, telephone number, or email you have on file with us. You have the right to transfer copies of your health information to another practice. You may have the right to see or receive a copy of your health information, unless there is a reason by law or contract why your therapist would not disclose the information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add the new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence

Avenue, S.W., Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact the owner of Eclipse Counseling LLC, Cory Tischman, via phone at 715-255-1117 or via email at info@eclipsecounselingcenter.com. For additional information regarding your confidentiality rights, please review our notice of HIPAA privacy practices.

Telehealth/Telemedicine Services

I hereby consent to engaging in telehealth/telemedicine at Eclipse Counseling, LCC as part of my psychotherapy and online counseling. I understand that online counseling/teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental information, both orally and visually.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to online counseling/teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and understand that my therapist will explain these to me in detail if I wish. The platforms used by Eclipse Counseling are HIPA compliant to protect my privacy and confidentiality.

I understand that I have the following rights with respect to online counseling/teletherapy:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Eclipse Counseling LLC, that: the transmission of my information could be disrupted or distorted by technical failures.
- In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
- I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.
- I understand using telehealth allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.
- I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

Technology: I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my online counseling/teletherapy sessions; (b) using www.doxy.me.com or the TherapyNotes platform; (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online counseling/teletherapy session; and (d) I also need to have a good broadband internet connection or a smartphone device with good cellular reception. I also understand that in case of technology failure, my therapist will call me back by phone, to complete our session.

Insurance Coverage: If using insurance, I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be and if telehealth services are covered.

Scheduling: I understand that scheduling is conducted through Eclipse Counseling and is based on my provider's normal clinic hours. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. If I am experiencing an emergency situation, I understand that I can call 911; or proceed to the nearest

hospital emergency room for help; or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support. I can also call Northwest Connections crisis line at 888-552-6642.

Video/Audio Recording: As a general practice, Eclipse Counseling DOES NOT record telehealth sessions without prior written consent.

Treatment of Minors

Treatment of children and adolescents is best done with the involvement of their custodial parents/legal guardians. Children with unmarried or divorced parents typically benefit from regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health. Therapy is confidential, but not secret. Parents/legal guardians are entitled to understand the nature of their child's problem as well as the method and course of treatment. Parents/legal guardians have the right of access to medical or mental health treatment, regardless of custody unless the custodial parents/legal guardians provide us with a court order limiting access or communication.

Parents/legal guardians may have access to the child's medical records, however, often with mental health records it is often determined to not be in the best interest of the child or adolescent. Wisconsin State Law entitles parents with legal custody to information regarding their child's treatment and generally entitles parents to copies of their child's health records. Wisconsin State Law allows for an exception to the release of copies of health records in the case of mental health. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to meet regularly with their child's therapist and to stay informed of what is occurring in therapy. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment.

In cases where there is joint (split) legal custody between caregivers who are not married or cohabitating, we require both caregivers' authorization and signature for treatment of their minor child/children. We believe it is best to identify and resolve potential parental conflicts or disagreements before treatment begins. We will not proceed with treatment if one custodial caregiver is unavailable or unwilling to consent and we do not have a note from the child's medical doctor determining that it is appropriate to proceed with the consent of only one parent. Counseling with children is done with the goal of providing an emotionally neutral setting to process current concerns and emotions. The usefulness of such therapy is extremely limited when the therapy itself becomes simply a matter of dispute between the parents or between parents and children. With this in mind, and in order to best help children in therapy we follow the following agreements in our therapy with minors:

1. Counseling and therapy will not yield considerations about custody. We recommend that parties who are disputing custody consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than settle a custody dispute in court.
2. The therapist of the child has the primary responsibility, as the child's therapist, to respond to the child's emotional needs. This includes, but is not limited to, contact with the child and each of their caregivers, and gathering information relevant to understanding the child's welfare and circumstances as perceived by important others (e.g. pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician should matters of the child's physical health be relevant to this therapy.
3. We ask that all caregivers remain in frequent communication regarding your child's welfare and emotional well-being. Open communication about his or her emotional state is critical. In this regard, we invite each of you to initiate frequent and open exchanges with your child's therapist.
4. We ask that all parties recognize and as necessary, reaffirm to the child, that the therapist is the child's helper and not allied with any disputing party or familial side.

5. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child including but not limited to these considerations:
    - We keep records of all contacts relevant to the child's wellbeing. These records are subject to court subpoena and may, under some circumstances, be solicited by parties (including attorneys) in divorce or other legal proceedings.
    - Any matter brought to your therapist's attention by either parent regarding the child, may be revealed to the other parent/caregiver. Matters brought to our attention that are irrelevant to the child's welfare may be kept in confidence.
6. We are not responsible for routine communication with caregivers who do not attend appointments and we cannot routinely contact the non-custodial caregiver(s) after each appointment. We are unable to send a summary letter, note, or e-mail after each appointment, unless payment arrangements have been made for this service. Expectation is that caregivers will communicate with each other openly regarding treatment and that each parent will cultivate a healthy relationship and open communication with their co-caregiver(s) and the child.

Emergencies
In case of a crisis after hours, you may call 211 or Northwest Connections Crisis Line at 1-888-552-6642. In the case of a life-threatening emergency, call 911 or go to your local hospital emergency care center. Phone consultations with clients, or parents/legal guardians of clients, during or after business hours, are not a part of the services we are able to offer at Eclipse Counseling. Please document any concerns you might have between appointments, and bring them to your next session so that we might discuss them. Phone consultations with prescribing physicians, school districts, and other collaborative services are always available free of charge for our clients, with your signed authorization for release of confidential information.

Telephone Accessibility
Your therapist is often not immediately available by phone because they do not answer the phone when in session with clients. Feel free to leave a voicemail and your therapist will get back to you within 4 business days (Monday through Thursday). We will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours Monday through Thursday). If you are difficult to reach, please leave times you will be available. If you want discretion used when calling you or leaving a message for you, please let us know in advance.

Electronic Communication
Electronic communication (email, fax, etc.) is a commonly used way of exchanging information. However, there is no guarantee that this form of communication is secure. Eclipse Counseling cannot ensure the security or privacy of the information exchanged. Email is not an appropriate means for communicating about your therapy or about a mental health emergency. Please do not email or use faxes for emergencies. Due to computer or network problems, messages may not be deliverable, and your therapist may not check emails, messages, or faxes daily.

You should also know that any electronic communication your therapist receives from you and any response sent back to you may become a part of your legal record and may be revealed if your records are summoned by a legal entity. If you communicate confidential or private information via electronic communication, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and your therapist and our clinic will honor your desire to communicate on such matters via electronic communication.

Social Media
Please note that Eclipse Counseling is on various social media websites as a way to market the services we offer. To protect your confidentiality Eclipse Counseling encourages you to consider the public nature of social media before liking, fanning or following our social media postings. Messaging on Social Networking sites such as Twitter, Facebook, Google+, or LinkedIn is not secure. It could compromise your confidentiality to use wall postings, @replies, or other means of engaging with Eclipse Counseling or your therapist online if we have an already established client/therapist relationship. It may also create the

possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you have questions, please contact your therapist who can help clarify questions you may have.

Financial Responsibility
Most health insurance plans include behavioral health coverage; however, the exact coverage varies widely with the different health insurance plans. Clients are responsible for services received not covered by insurance; therefore, we strongly recommend you call your insurance company to verify your coverage. When you call your insurance company, ask to verify your coverage for outpatient mental health. It is also your responsibility to keep us up-to-date with any changes in your benefit plan and/or insurance coverage. We understand that insurance is tricky, but we are not responsible for verification of your insurance benefits and we cannot be held responsible for insurance coverage denials.

Disability or Other Paperwork
Completion of forms such as FMLA, SSA, disability paper or any other paperwork directly related to your cares needs to be discussed first with your therapist. The paperwork completion will take place at your individual time with your therapist.

Release of Records
The laws and standards of this profession require that we keep treatment records. You are entitled to examine and/or receive a copy of your records if you request it in writing. In order to see your records, you and your therapist will need to discuss the contents together. Because these are professional records, they can be misinterpreted and/or be upsetting to people who are not mental health professionals.

Ending Treatment
You have the right to end your treatment at any time without your therapist's permission or agreement. However, if you do decide to exercise this option, we encourage you to talk with your therapist about the reason for your decision in one or more termination sessions so that we can bring sufficient closure to our work together. We can also discuss any referrals you may need at that time.

As a therapy service, we also reserve the right to terminate therapy at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, or patient needs that are outside of the therapist's scope of competence or practice. If we are to end treatment we will provide you with referrals to another provider or service we believe to be appropriate.

If during therapy either you or the therapist assigned to you is not effective in helping you reach your therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, we will provide a number of referrals that may be of help to you.

Client Bill of Rights
As a consumer of mental health services, you have the right to:

- expect that the provider has met the minimal qualifications of training and experience required by state law;
- examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;
- obtain a copy of the Rules of Conduct at: https://www.dhs.wisconsin.gov/clientrights/intro.htm
- report complaints to the Board of Behavioral Health and Therapy;
- be informed of the cost of professional services before receiving the services;
- privacy as defined and limited by rule and law;
- be free from being the object of unlawful discrimination while receiving counseling services;
- have access to your records as provided in Wis. Stat. § 51.30;
- be free from exploitation for the benefit or advantage of the provider;
- terminate services at any time, except as otherwise provided by law or court order.

Rates

Billing Code	Service	Length of Visit	Rate	Day-of-Service Payment
90791	Initial Intake/Reopen	50-60 minutes	$260	$130
90832	Psychotherapy 30 minutes	16-37 minutes	$100	$50
90834	Psychotherapy 45 minutes	38-52 minutes	$160	$80
90837	Psychotherapy 60 minutes	53-60 minutes	$220	$110
90847/90846	Family/Relationship Therapy	45-50 minutes	$220	$110
90785	Interactive Complexity (add on)	30 minute units	$100	$50
90839/90840	Psychotherapy for Crisis	Add 60/30 minutes	$240/$120	$120/$60
90853/90849	Group Therapy	60-90 minutes	$100/$200	$50/$100
H2019	DBT Group Therapy	15 minute units	$50/unit	$25/unit
Billed to Client	Phone Calls, Letters, Emails or Reports	15 minute units	$30/unit	N/A
Billed to Client	Court Appearances or any legal request	Varies	$350	N/A
Billed to Client	Late Cancel or No Show	N/A	$50	N/A

BILLING INFORMATION & POLICY

Payment for Services

Fees are set with your insurance. If you are paying out of pocket, please refer to our attached fee schedule. If your insurance denies our claim, you are responsible for the full amount. An account sent to a collection agency is assessed with a $25.00 late fee in addition to the balance owed. Your payment/bill is due at the time of services rendered. **If you changed your insurance and failed to inform us, you will fully be responsible for the balance owed to us.**

Client or Guardian Initials: (_____)

Late Cancellation/No Show Appointments:

Late Cancel: canceling or rescheduling an appointment **after** 3pm the day before the scheduled appointment.

No Show: not appearing for a scheduled appointment and not giving any advance notification, or showing up more than twenty (20) minutes late to the scheduled appointment without any advance notification.

A **late cancel** or **no show** appointment hurts three people: you, your therapist, and another client who could have potentially utilized your time slot. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice or missed altogether, we are unable to fill this time slot by offering it to another current client, or a client on the waitlist. In addition, we are unable to bill your insurance company for sessions that are not kept. A **no show** may result in your future appointments being cancelled and a notification to you of this action. **Client/Guardian Initials: (_____)**

State Insurance/Medicaid: Please note that fees cannot be applied for clients with Medicaid insurance. Thus, clients with Medicaid insurance who have a combination of three or more late cancels and/or no shows in calendar year will need to speak with your therapist before making any further appointments to address barriers you may be experiencing which prevent you from attending your scheduled appointments, and discuss what we can do to help you commit to this care. **Client/Guardian Initials: (_____)**

Private Insurance or Self-Pay: A fee of **$50** will be charged for a **late cancellation** or **no show**. You can cancel or reschedule your appointment by using the patient portal, email, or calling the office. A late cancel/no show fee will be submitted to the credit or debit card on file for clients with private insurance coverage, which includes cash clients. This charge is submitted on the date of service only if the client misses an appointment without giving proper notice to cancel or does not show up

to a scheduled appointment without notice. The fee may be waived for the first late cancellation or no show. **Client/Guardian Initials: (_____)**

In the case of multiple missed appointments, we reserve the right to require that you pre-pay for future appointments and/or cancel all future appointments. A total of 2 *non-payments* for **late cancels** or **no shows** will result in all of your future appointments being cancelled. Future sessions will only be scheduled once payment is received for the missed sessions. **Client/Guardian Initials: (_____)**

Additionally, please understand that therapy should be viewed as any other important medical appointment would be viewed. While it is a time commitment, this is for your personal betterment and consistency is key in order to achieve this. Because your therapist believes that the responsibility for your care is on both the client and the therapist, they agree that if they miss an appointment without notice, or they are more than fifteen (15) minutes late for your appointment, you will receive a FREE therapy session. **Client/Guardian Initials: (_____)**

Late Policy
If you are late, your session will still end at the scheduled time. Please remember that individual, relationship, and family therapy times may depend on your insurance set time. Being 20 minutes late without any notification will result in a **no show. Client/Guardian Initials: (_____)**

Private Insurance Clients

Billing Statement & Balance on your Account
You will not receive a statement for services that are the responsibility of their insurance company. Nor will you receive a statement if the balance has been paid in full on each date of service, and the account is current. This will be given to you in person, emailed, or will be mailed to your home address with us. *Your payment is due upon receipt. It is your responsibility to pay your bill* and our practice will only send you the billing statement to remind you of your balance and a request for payment from you. **A balance of $300 or more will result in putting your services on hold**. We may cancel all future appointments if the account is not settled in full. This will assist with keeping the account up to date and help you in terms of not getting into further debt and having a high balance on your account.
Client/Guardian Initials: (_____)

Collections
If no payment is received after 60 days on the date of the billing statement, your account will be sent to our collection agency. Once your account has been submitted to our collection agency, all of your future appointments will be cancelled until you settle your account. Accounts sent to a collection agency are assessed with a $25.00 late fee in addition to your balance owed. I understand that if I default on any payment obligations as called for in this agreement Eclipse Counseling LLC will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account, up to an additional 30% will be assessed to my account to cover the costs of this action. I agree to pay all costs of collection, including but not limited to collection agency fees, court costs, and attorney fees. I understand and give my consent for Eclipse Counseling LLC, to forward my information to collections, should I default on this agreement and fail to pay my Balance Due. **Client/Guardian Initials: (_____)**

Payment Plan
We will gladly work with you within the 60-day grace period to set up a payment plan with us. Once a payment plan has been put into place, there will be no interruptions of services. However, if you fail to honor your payment plan, future appointments will be cancelled once more until you are caught up with your account balance. ***It is not ethically sound of us to allow clients to have a high balance on their account.*** **Client/Guardian Initials: (_____)**

Deductibles and Copays
Private insurance has deductibles and copays. Payment is due upon receiving services from us. It is your responsibility to read your insurance policy on deductibles and copays. If payments are not made on the date of service, or if arrangements

for an alternate payment plan have not been made, charges will be submitted to the client credit or debit card on file in our office. Non-payment of your deductibles and/or co-pays will result in your services being put on hold and we will cancel all of your future appointments until payment is made.
Client/Guardian Initials: (_____)

Lapse in Coverage
Any counseling services that are not eligible for coverage through a client's insurance plan become the responsibility of the client or financially responsible party. If not paid on the date of service, these charges will be submitted to the credit/debit card on file either on the date of service, or on the date we receive notice that services have been denied. Receipts for all credit or debit card transactions will be mailed to clients along with their statement. Payments due that are not paid are subject to fees within the limitations of the law. **Client/Guardian Initials: (_____)**

Insurance/EAP Authorizations – It is your responsibility to request an authorization from your insurance company if their policy requires. It is not our responsibility to request an authorization for your initial session or ongoing appointments, as it is your insurance. **Client/Guardian Initials: (_____)**

Using your Employee Assistance Program (EAP) & Continuing treatment after your EAP benefits – It is your responsibility to provide us all the necessary insurance information, including a copy of your insurance ID card. Please see the above policy on insurance authorization if this applies to you. We cannot schedule an appointment until we receive all the required authorizations. **Client/Guardian Initials: (_____)**

Self-Pay: If you pay for psychotherapy services out of pocket or if you have an insurance deductible, you can take advantage of the day-of-service rate. This reduced rate can be paid in cash, debit, HSA, or credit card on the day of service only. You will also receive a Good Faith Estimate with the estimated cost of services. We do not accept personal checks. **Client/Guardian Initials: (_____)**

Credit Card Information
We require all clients to keep a credit card on file in accordance with the above billing policy. I agree that the card I provide to my therapist to keep on file can be used to process payments that are my responsibility.
Client/Guardian Initials: (_____)

Court Issues
Our services are not to be utilized for testimony, custody disputes, disability or any other form of court evaluations. We are happy to refer you to other providers in the area who provide these services should you require any court evaluation or testimony. Should we be subpoenaed or mandated by the courts to testify, you will be required to pay all fees, in advance, associated with the writing of case summaries and/or other reports, consultation with attorneys, consultation with mental health professionals, review of other records, and any other preparation. The client will also need to pay for other fees incurred including travel time, meals, parking and all other costs associated with the court time. Therapist testimony will require that the client be billed directly, as insurance will not cover these charges. All fees must be paid prior to the date of testimony. Court appearances are significantly more expensive due to the complexity and difficulty of being involved in such matters. Our current hourly rate for any legal related matters is $350 per hour. Please note: these fees apply to any court-related or legal-related work regardless of whether testimony ends up being required. Any legal fees are outside of insurance and outside of what is considered a mental health care service.
Client/Guardian Initials: (_____)

Phone Calls, Letters, Emails
If communication (email or phone calls) outside of therapy requires more than 10 minutes to respond to, we may charge services rendered in 15-minute increments. Please indicate if you intend to pay these charges, or we will save it for review during your appointment time. Letters to institutions, companies, work, school, court, military, and other third parties for

the purpose of verifying your participation in counseling, as well as other letters that we have to write on your behalf will be billed separately. A letter containing treatment summaries and diagnostic impressions which requires more than 30 minutes of billable time will be billed at a flat rate of $75.00. A simple form letter for attendance verification is available upon request. A small per-page printing charge may be assessed for printing.
Client/Guardian Initials: (_____)

Additional Charges
You are entitled to examine and/or receive a copy of your records if you request it in writing. In the event of a request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee based on the current legal maximums allowed by the Department of Health. Copies of records are available for a $17.21 processing fee, plus $1.30 per page for copying. At times, a workbook is required to attend and attend counseling treatment. Workbook fees vary, and your counseling will discuss this with you.
Client/Guardian Initials: (_____)

By signing this document, I hereby acknowledge the following: I am of sound mind and am fully competent to give informed and willing consent for therapy, either for myself and/or a minor child; I have read and understood the information regarding Informed Consent for Treatment and billing & payment policy; I have had the opportunity to ask any questions that I want to ask concerning the proposed treatment, services, and billing; I understand that a copy of the Informed Consent form is available for my own use upon request; I have received and have been given an opportunity to read a copy of Eclipse Counseling's Notice of HIPAA Privacy Practices; I have been offered a copy of Eclipse Counseling's Client Rights and the Grievance Procedure Brochure and have been given an opportunity to discuss my concerns and questions; I take full responsibility for any outstanding bill for services rendered; I authorize Eclipse Counseling LLC to pursue any outstanding balance due to them should I not follow the clinic policy; I authorize insurance benefits to the paid directly to Eclipse Counseling LLC and that Eclipse Counseling may release any information to my insurance provider(s) or other payer source(s) for processing my claims; and I understand that payments are due on the date of service.

Client Signature (if age 14 or older) Print Name Date

Signature of Guardian/Legal Rep. Print Name Date

Relationship to Patient (if patient is a minor). Check below to indicate the custody status if patient is a minor:

- ☐ Parents are married to each other and both are legal parents to the child/minor.
- ☐ I am a single parent, with legal and physical custody of the child/minor.
- ☐ The child/minor's other parent and I share legal custody. Consent must be obtained from the other parent to continue service.
- ☐ This child/minor is in custody of the State of Wisconsin. County:_____.
- ☐ Guardian/legal representative of child/minor.