18 Carlisle Street, Suite 108
Gettysburg, PA 17325
Phone # 717-420-5395
Fax # 717-724-5432

Patient Information, Service Policies, and Consent For Treatment

Name of Patient: _____ Date of Birth: ____/____/_____

Street Address : _____

City/ State /Zip: _____

Home phone: _____OK to contact? __Yes__No Cell phone: _____OK to contact?__ Yes ____ No

Email address: _____ Ok to contact? __Yes __No

Name, Address, Phone of Primary Care Physician:_____

_____

EMERGENCY CONTACT: (by signing on p. 3 of this agreement, you give consent for us to contact this person in event of an emergency)

NAME: _____RELATIONSHIP_____PHONE: _____

I, (print name) _____, **the patient or legal guardian, understand that it is my responsibility to do the following:**

1. Determine whether or not Rebecca Uppercue, LCSW (tax ID #47-1389214) is a participating provider with my insurance.

3. Obtain accurate information on the amount of my co-payments, deductible, and the number of sessions authorized by my insurance company.

4. Determine if provider pre-authorization is required. **YES*** / **NO** *If **YES**, **__Before 1st appt ____ In __# of sessions**

4. I must provide Rebecca Uppercue with all of this information by the first session or at least 3 business days prior to 1st session if provider pre-authorization is required.

5. I must provide any changes in insurance (including showing new insurance cards when they are received) to Rebecca Uppercue for copies/processing my claims.

If Rebecca Uppercue is a participating provider for my insurance provider or has an agreement with my insurance company, she will submit insurance claims for me if I sign the release below. However, I will need to find out the details of my insurance policy for mental health coverage, including deductibles, co-pays, preauthorizations, physician referrals, and other limits. If Rebecca Uppercue is a participating provider with my insurance plan, I authorize payment of insurance benefits directly to her/Gettysburg Counseling, LLC. In the event of overpayment, the overpayment will be refunded to either my insurance company or to me, as appropriate. In the event of an insurance company not covering services as originally quoted to me, I will be held responsible for the balance I may owe to Gettysburg Counseling, LLC on my account.

I understand that my insurance company may request information about me, my treatment, or mental/physical condition. I authorize release of such information by Gettysburg Counseling, LLC. I permit a copy of this authorization to be used in place of the original. I have reviewed, understand, and am in agreement with the policies in this statement.

I, (print name) _____, **the patient or legal guardian consent to treatment and will adhere to the following service policies and procedures:**

Goals and Expectations: To obtain maximum benefit from counseling services, I agree to be an active participant in treatment, which includes keeping all scheduled appointments, following through with referrals, and completing activities discussed in session. An individualized treatment plan (my goals and objectives for treatment) will be developed by my fifth session to monitor my progress. The ultimate goal of services is to eventually be discharged from treatment following obtaining a sense of wellbeing and the accomplishment of my treatment goals. As I voluntarily consent to treatment, I am also free to withdraw consent and discontinue treatment at any time. Similarly, this practice has the right to refer me to a more appropriate treatment setting. If I do not remain active in treatment or allow more than 60 days to pass without contact (session or phone consultation), Gettysburg Counseling, reserves the right to close the treatment file.

Attendance is important for personal growth/healing as well as keeping my case active and avoiding cancellations fees and/or closure of my case. Last minute cancellations (within 24 hours of appointment time) or missed ("no-show") appointments will result in a full session fee of $50.00 and may cause eventual termination of services. Therapy will be refused if I arrive to the therapy session late, intoxicated, or impaired. I acknowledge I will not be charged for a cancellation if the schools in the county in which I reside are closed due to inclement weather.

Payment: I agree to pay for each session at the end of each meeting. Payment is accepted by cash, personal check (made out to Gettysburg Counseling, LLC), Visa, Mastercard, Discover, or American Express. I have the right to request a detailed receipt for my record and/or submission to my insurance company for possible reimbursement for services.

Fees: **Evaluation (60 minute initial session) - $120.00**

Individual, Family, Marital Counseling - 45 minute session - $90.00

Missed Appointment or Late Cancellation (within 24 hours of appointment time) – $50.00
******Not billable to insurance and must be paid prior to next session***

Telephone Consultation over 10 minutes - $25.00 per 10 minutes

Letter Writing - $25.00 per letter

Court Appearance - $395.00 for 3 hours (minimum cost) - must be prepaid prior to court date

Returned Check/ Insufficient Funds - $30.00 per occurrence

Copy of medical record to another agency - $20.00 for up to 20 pages + $0.15 /additional page

Confidentiality: I acknowledge confidentiality of records maintained by Gettysburg Counseling, LLC/owner, Rebecca Uppercue, LCSW is protected by federal regulation. This practice may not disclose any information to outside sources regarding a patient's treatment unless the patient given written consent. However, there are exceptions, as mandated by Pennsylvania law:

- Information provided leads to the suspicion of child or elder abuse/neglect
- I threaten to/ or engage in behavior which leads my therapist to suspect I will harm myself, others, or property
- Authorization/subpoena by court order
- Medical emergency, to meet a bona fide medical emergency when there is immediate threat or safety issue

*In the aforementioned circumstances, this information will be provided to legal authorities and/or emergency contact persons to insure my safety and those in association with me.

In addition, by electing to pay by credit card or check, I acknowledge my name, bank/credit account information may be associated with treatment services provided by Gettysburg Counseling, LCC by third parties in order to secure payment for services and manage financial accounts/medical records.

Safety: I acknowledge the safety of patients and staff in this office is paramount. This practice will not tolerate threats, harassment, aggression/violence, or the carrying of any alcohol, drugs, or weapons by patients. These aforementioned behaviors will result in immediate discharge from treatment. Federal regulations do not protect information about a crime committed by a patient either at the counseling practice or against any person who works at the practice, or about any threat to commit such a crime.

Contact: Voicemails are checked regularly and Ms. Uppercue will return my call within 24 hours during business days. **Email or phone contacts are neither confidential nor secure, so clinical information and suggestions will not be provided by email, phone, or text.** If I am in need of immediate assistance due to an emergency or suicidal/homicidal thoughts, I understand it is imperative I contact the following urgent/emergency care facilities for treatment:

National Crisis Hotline	**Gettysburg Police Department**	**Wellspan Crisis Intervention Hotline**	**Gettysburg Hospital**
1-800-273-8255	**717-334-1168**	**800-673-2496**	**717-334-2121**

If I live in a county other than Adams County, I will call my local police department or hospital for care.

Children and Pets: I agree to arrange for child care for children (not directly involved in treatment) to assist me with maximizing my attention to my therapy. Other than service animals, pets/animals are not permitted in the building. I acknowledge that I will be held responsible for any damage to the building, furniture, or supplies caused by me, family, children, or pets.

***By signing below, I acknowledge I have read and understood all of the policies and procedures delineated in this agreement and voluntarily give consent for treatment under such policies and procedures.**

_____ _____

Patient or Legal Guardian

Rebecca Uppercue, LCSW

Licensed Clinical Social Worker

_____ _____

Date

Date