



## INFORMATION FOR MY CLIENTS

From B. Gayle Luster, M.A., L.P.C.

I want to welcome you to my office. There are several things you need to know before we get started. If you have questions about anything covered here - be sure to let me know. I have a master's degree in counseling psychology. I am licensed as a professional counselor. I have been practicing as a psychotherapist since 1990. The services I provide include: individual, marriage, family, and group counseling. The specific kind of service you will receive depend greatly on the nature of the problems you are experiencing. We will work together to develop an appropriate treatment plan for you.

### Therapy Sessions

1. Therapy sessions are 50 minutes long.
2. The normal fee per session is \$100.
3. I am also a member of several managed care panels. If your insurance company has referred you to me, you will be charged according to my contracted rate with that company.
4. I reserve your session time for you. If you are unable to be here for your appointment, please call me at least 24 hours in advance so that someone else can have your time. **If you do not call me at least 24 hours in advance, you will be billed for the missed session.**

### Confidentiality Information

1. The content of your therapy sessions is almost always confidential. By law, I must report actual or suspected child or elder abuse to the appropriate authorities. In addition, I have a legal responsibility to contact the proper authorities when there is a probability of imminent physical harm by a client to him/herself or others. Additionally, I must release your records when a court orders me to do so.
2. Except as described above, your treatment files will be kept private. If you would ever like me to release these records to someone else, you must let me know in writing.
3. Your insurance company may ask me to provide them information about your treatment plan. I will do this in accordance with the HIPAA privacy rules. If you do not want me to disclose any information to your insurance company, you must let me know in writing.
4. If you have questions about these limits of confidentiality, please ask me directly.

### Payment and Insurance

1. Full payment for each session is to be made at the time of your appointment unless prior arrangements have been made. I accept cash, checks, Master Card, Visa. There will be a \$15 processing fee for any returned check.
2. If you are filing your own insurance and would like a detailed receipt, please let me know.
3. If I file insurance for you, there are several things you need to know.

- a. I will call to verify your benefits with your insurance company. Telephone verification does not guarantee exact payment. Sometimes what an insurance company verifies and what they pay are different.
- b. **If your insurance company denies payment or pays a different amount, you are responsible for the balance.**
- c. If you miss an appointment, your insurance company may not pay for the session and you will be responsible for the entire balance due.
- d. If you have questions about your benefits, you should call your insurance company directly.
- e. Your signature on this sheet serves as your signature on file and verifies your desire to have insurance benefits assigned to this provider.
- f. I will be disclosing information about the dates of your sessions and your diagnosis to your insurance company to receive payment from them.

4. Based on a preliminary telephone verification:

Your insurance company is: \_\_\_\_\_

Your co-pay is \$\_\_\_\_\_ per visit

**Balances Due**

- 1. Getting payment from your insurance company is ultimately your responsibility. If your financial status prohibits treatment with me, I will be happy to refer you to alternative agencies.
- 2. If no payment is received on an account with an outstanding balance for a period of 60 days, the account may be turned over to a collection agency. If your account is turned over for collection, you will be responsible to pay all costs incurred in the collection process including an 18% interest charge on all outstanding debts.

**Who May We Contact?**

- 1. May we contact your primary care physician if necessary to coordinate your care? If yes, please provide the name and phone number of your doctor.  
 YES \_\_\_\_\_ NO \_\_\_\_\_

Doctor's Name and Office Number: \_\_\_\_\_

- 2. May we contact the person who referred you to us only to thank them? We will not disclose anything about you or your treatment plan with them. We only want to acknowledge their referral.  
 YES \_\_\_\_\_ NO \_\_\_\_\_

- 3. May I send my monthly newsletter to your email address?  
 YES \_\_\_\_\_ NO \_\_\_\_\_

I / We have read, understand and agree to follow these policies.

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date