



SEYLER - BERKEBILE MARRIAGE & FAMILY THERAPY

COURTNEY SEYLER, MA, LMFT • AMANDA BERKEBILE, MA, LMFT • & ASSOCIATES

Client Information

A. Identification

Client name: _____ Date of birth: _____ Age: _____

Spouse name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ e-mail address: _____

B. Parent / Legal Guardian

Name: _____ Relationship to Client: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ e-mail address: _____

C. Insurance Information

Primary Insurance: _____ Insurance Phone: _____

Name of Policy Holder: _____ Relationship to Client: _____

Policy Holder address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Social Security Number: _____ Employer: _____

Identification Number : _____ Group Number: _____

D. Employee Assistance Program Information (EAP) / Secondary Insurance

EAP / Insurance Name: _____ Phone: _____

Authorization / Insurance Number: _____ Number of Sessions: _____

E. Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

_____ My therapist may call me at my home.

_____ My therapist may call me on my cell phone.

_____ My therapist may call me at work. My work number is () _____

_____ My therapist may send mail to me at my home address.

_____ My therapist may communicate with me by email.

I certify that the information listed above is accurate and true. I am aware that, unless I am a private pay client, payment for this service will be from one or more of the insurance carriers listed above and that any false claims, statements, documents, or concealment of information may be prosecuted under applicable federal and state laws. I understand that I assume financial responsibility for all normal and customary charges that are not paid for by my insurance carrier(s). In addition, I agree to pay for those services that I request that are not reimbursable by my insurance carrier.

Signature of client (or person acting for client and relationship to client)

Date





Consent for Treatment

Please initial each section below to acknowledge that you have read and understand what has been stated. Your therapist's name is _____ and can be reached any time at (724) 832-1700. Please leave a message and the call will be returned as soon as possible. If you have a counseling emergency after hours please dial 911.

_____ *Confidentiality*

Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission.

1. There are certain situations in which this therapist is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:
 - a. If you threaten bodily harm or death to another person, this therapist is required by law to inform the intended victim and appropriate law enforcement agencies.
 - b. If you threaten bodily harm or death to yourself, this therapist will inform the appropriate law enforcement agencies and others who could aid in prohibiting you from carrying out your threats.
 - c. If you reveal information related to the abuse or neglect of a child, dependent adult or elderly person, this therapist is required by law to report this to the appropriate authorities.
2. If you become or are already involved in a court case or proceeding and this therapist's testimony or records are subpoenaed by a judge.
3. If you provide insurance to pay all or part of the fees you incur in treatment.
 - a. If you use your health insurance to pay part of the fees, the insurance company, the managed care organization, or perhaps your employer's benefits office may require this therapist to provide information about your functioning in many areas of your life, your social and psychological history, and your current symptoms. This therapist may also be required to provide a treatment plan and information on how you are doing in therapy.
 - b. If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information.
4. If your account with this therapist is unpaid and we have not arranged a payment plan, this therapist can use legal means to get paid. The only information this therapist will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due.
5. At times therapy will involve the participation of more than one family member and/or significant persons. If we are doing Couple or Family Therapy, while this therapist will attempt to follow your wishes, confidentiality is not guaranteed among participants in the therapy.

(Consent cont.)





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Financial Responsibility and Fees

The length of each session is **50 minutes**. If paying by cash you will be informed of the cost of the session prior to the start of the session. You agree to be financially responsible for all charges incurred at this practice including your insurance deductible, co-payment and any services rejected by your insurance company. An insurance contract is between the client and the client's insurance company; therefore, it is always the responsibility of the client to pay all of their treatment.

Payment / co-payment is required at the time of service; if payment is not made a **\$5.00 fee** will be assessed. If you are unable to attend your scheduled appointment, you must call **12 hours in advance** or you will be charged a **\$25.00 fee**.

Services

You hereby seek and consent to take part in the treatment by this therapist. You understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in your best interest. You agree to play an active role in this process.

You understand that no promises have been made as to the results of treatment or of any procedures provided by this therapist.

You are aware that you may stop your treatment with this therapist at any time. The only thing you will still be responsible for is paying for the services you have already received. You understand that you may lose other services or may have to deal with other problems if you stop treatment. (For example, if your treatment has been court-ordered, you will have to answer to the court.)

You are aware that an agent of your insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments you receive. You understand that if payment for the services you receive here is not made, the therapist may stop your treatment.

Your signature below shows that you understand and agree with all of these statements.

Signature of client (or person acting for client and relationship to client)

Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date





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CONSENT TO TREATMENT / ENCOUNTER FORM

Client Name: _____

I certify that I am the client, legal guardian, or custodial parent requesting services as deemed necessary by my therapist from this office. My signature certifies that I have received a service on the date listed below.

| ENCOUNTER | DATE | RECIPIENT'S SIGNATURE | CBT CODE |
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