ENJOY LIFE MORE

C0UNSELING AND COMMUNICATION SERVICES

PENNIE J. MCKAY, MA, LCPC, LMFT, NCC
Licensed Clinical Professional Counselor
Licensed Marriage and Family Therapist

CLIENT INFORMATION

NAME:____________________________ AGE:_____ DOB:________DATE:________

ADDRESS:____
STREEET CITY/STATE ZIP CODE

HOME PHONE:_____________________ WORK PHONE:________________________

CONCERN(S):____

REFERAL SOURCE:____

PREVIOUS COUNSELING:____

PRIMARY PHYSICIAN:____

HEALTH ISSUE(S) AND/OR MEDICATION(S):__________________________________

SUPPORT PEOPLE:____

CONFIDENTIALITY: **ALL INFORMATION SHARED WITH THE THERAPIST SHALL REMAIN CONFIDENTIAL EXCEPT IN THE FOLLOWING CERCUMSTANCES; 1) THERAPIST HAS REASON TO BELIEVE THAT THE CLIENT IS IN DANGER OF PHYSICALLY HARMING HIM/HER SELF OR SOMEONE ELSE. 2) "RELEASE OF INFORMATION" FORMS HAVE BEEN COMPLETED TO AUTHORIZE THE SHARING OF INFORMATION WITH SPECIFIC INTERESTED PARTIES. 3) THE CLIENT IS A MINOR AND THERE IS SIGNIFICANT REASON FOR THE THERAPIST TO BELIEVE THE PARENT(S)/GAURDIAN(S) NEED TO BE INFORMED OF CONCERNS AND/OR CHANGES. 4) RECORDS ARE SUBPOENAED. OR 5) AUTHORIZED INSURANCE CAMPANIES REQUEST SPECIFIC INFORMATION IN DETERMINING PAYMENT.**

CONSENT FOR TREATMENT: **IT IS IMPORTANT THAT THERAPY BE BASED ON HONESTY AND COOPERATIVE WORK BETWEEN THE THERAPIST AND THE CLIENT. IF YOU AGREE TO BE AN ACTIVE PARTICIPANT IN THIS PROCESS PLEASE SIGN IN THE SPACE PROVIDED BELOW. IN SIGNING THIS YOU ARE ALSO AGREEING TO PROVIDE PAYMENT FOR SERVICES AS OUTLINED ON THE NEXT PAGE.**

____
CLIENT SIGNATURE DATE

____
PARENT/GAURDIAN SIGNATURE DATE

____
WITNESS DATE

FINANCIAL INFORMATION

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE UNLESS ARRANGEMENTS HAVE BEEN APPROVED BY PENNIE J. MCKAY, MA, LCPC, LMFT, NCC. -1674 HILL RD., #7-BOISE

CANCILATIONS AND/OR RESCHEDULING -------------24 HOUR ADVANCED NOTICE IS REQUIRED, OR THE CLIENT/PARENT WILL BE RESPONSIBLE TO PAY FULL FEE FOR THE MISSED APPOINTMENTS.

CURRENT FEES:

INTAKE SESSION ------------------------$125 PER 50 MIN. SESSION
INDIVIDUAL THERAPY ----------------$100 PER 50 MIN. SESSION
FAMILY/COUPLE THERAPY ----------$100 PER 50 MIN. SESSION
GROUP THERAPY ------------------------$ 55 PER 90 MIN. SESSION
CONSULTATIONS ------------------------$100 PER 50 MIN.
ASSESSMENTS ----------------------------$100 PER 50 MIN. (ADMIN, SCORING, ETC)
PHONE CONTACTS ----------------------$ 65 PER 15 MIN.
HOSPITAL & COURT WORK ----------$300 PER HOUR

UNPAID BALANCES HELD OVER 6O DAYS WILL RESULT IN SUBMISSION TO A COLLECTIONS AGENCY. CLIENTS ENTERING INTO THERAPY, AND WHO HAVE SIGNED THE PREVIOUS PAGE'S "CONSENT FOR TREATMENT" ARE ALSO AGREEING TO PAY ALL ATTORNEY AND/ORCOLLECTION FEES IF THEIR ACCOUNT IS PLACED IN THE HANDS OF AN ATTORNEY FOR COLLECTION OR SUIT.

FINANCIALLY RESPONSIBLE PERSON:____

DOB:________________________________ EMPLOYER:____________________________________

ADDRESS:____
STREET CITY/STATE ZIP CODE

HOME PHONE:_______________________________ WORK PHONE:_______________________________

PRIMARY INSURANCE:_______________________________ PHONE:_______________________________

ADDRESS:____
STREET CITY/STATE ZIP CODE

SUBSCRIBER NAME:____ DOB:____________________

POLICY #:________________________ ID #____________________________ GROUP #:__________________

IF YOU WOULD LIKE TO PROTECT AND CONTROL THE AMOUNT OF CONFIDENTIAL INFORMATION AVAILABLE TO INSURANCE PERSONEL IT IS RECOMMENDED THAT YOU PAY FOR YOUR THERAPY DIRECTLY AT THE TIME OF SERVICE. BE SURE TO ASK FOR A RECEIPT.

IF YOU WOULD LIKE YOUR INSURANCE BILLED PLEASE READ AND SIGN THE FOLLOWING: **1)** I AUTHORIZE THE ABOVE INSURANCE COMPANY TO PAY PENNIE J. MCKAY, MA, LCPC, LMFT, NCC DIRECTLY FOR THE SERVICES I HAVE RECEIVED. **2)** I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES AND THAT PAYMENT PROBLEMS REMAIN BETWEEN THE INSURANCE COMPANYAND ME. **3)** I AGREE TO PAY THE CO-PAYMENT PORTION OF THE FEE AT THE TIME OF SERVICE. **4)** I AGREE TO PAY THE BALANCE DUE PORTION ON A REGULAR BASIS, NOT TO BE MORE THAN 30 DAYS PAST THE DATE OF SERVICE. **5)** I AGREE TO PAY FOR ALL APPOINTMENTS I MISS, IF I HAVE NOT CANCELLED THEM AT LEAST 24 HOURS IN ADVANCE. AND, **6)** I CONSENT TO PERSONS CONTRACTING WITH MS. MCKAY (i.e. ANN WOODY, (208)336-8384) UTILIZING MY FINANCIAL INFORMATION TO COMPLETE AND SUBMIT INSURANCE CLAIMS.

_______________________________________ _______________________________________
SIGNATURE DATE WITNESS DATE