

Confidentiality

When working together the information you share with me is kept in strict confidence with a few exceptions. By law, I am required to report to the proper authorities any person who is a danger to themselves or to others, or who is gravely disabled. In addition, I must report all instances of suspected physical and sexual abuse and neglect of children, the elderly, or the disabled. My records can be subpoenaed by a court of law in criminal liability cases and those involving child custody disputes. At times I consult with other therapists. I do not use names or other identifying information as part of the consultation. I will endeavor to release and disclose the minimum information necessary for payment from insurance or an Employee Assistance Program. All other disclosures require a signed Release of Information (ROI) which I can provide you upon request.

Payment Policy

Hourly Individual Sessions have different durations. Sessions lasting 45 minutes are \$150.00 per session. Sessions lasting 60 minutes are \$195.00 per session. Initial intake sessions may last up to 90 minutes and the fee for an intake session is \$275.00. You are responsible for any balance not covered by your insurance provider. As a Licensed Professional Counselor, my services are covered by most insurance providers, however it is your responsibility to determine if mental health services are covered and who is covered to provide the services. Any unpaid balances will be your responsibility. Unpaid balances will be turned over for collections after 90 days unless other arrangements are made. At that time I reserve the right to terminate services and to refer you for services elsewhere. Any and all fees associated with collecting unpaid balances will be added to the total amount owed. Session fees may change with two weeks advance notice.

Cancellation Policy

When an appointment is made, that time is set aside for you. As a result, I require a 24 hour notice (one business day) for cancellations. If the appointment is not cancelled, a missed appointment fee of \$100 will be charged and is payable prior to reschedule. At my discretion I may excuse a late cancellation due to extenuating circumstances provided the appointment is cancelled before the scheduled appointment time. Insurance does not cover for missed appointments.

Emergency and After Hours

Messages can be left 24 hours a day on my confidential voicemail (907.538.4622). I will attempt to return all calls within one business day Monday through Friday, unless I am out of the office. I am not able to provide 24 hour a day emergency care. If you have an after hours emergency, please call the crisis intervention hotline at 907.563.3200, call 911, or go to your nearest emergency room. If your need exceeds what I can provide, we will need to discuss alternative plans.

Consent for Treatment

By signing below, I acknowledge I have read & I understand these policies and consent to receive therapy services.

_____ Client Signature	_____ Printed Client Name	_____ Date
_____ Parent/Guardian Signature (client under 18)	_____ Printed Parent/Guardian Name	_____ Date
_____ Witness Signature	Julie Shewman, LPC _____ Witness	_____ Date

Client Information

Today's Date: _____

Julie Shewman, LPC

Client Name	Date of Birth	Contact Phone <input type="checkbox"/> Ok to leave messages on this phone
Address (Street, City, ST, Zip)	Client Social Security Number	Client Employer Name and Position
Emergency Contact	Emergency Contact Phone	Relationship to client

Payment Responsibility – Who is responsible for payment

Name <input type="checkbox"/> Client (If client go to next section)	Relationship to Client	Date of Birth
Address	Social Security Number	Primary Phone Number

Insurance Information (Please fill this out and bring your insurance card to first session.)

Insurance Company	Plan Name	Name of Policy Holder (Insured's name) <input type="checkbox"/> Client <input type="checkbox"/> Other:		
Insured's ID #	Insured's Employer	Insured's Date of Birth		Insured's SSN
Address for Claims	Claims Phone Number	Deductible	Copay	Amt pd to deductible

Secondary Insurance Information

Insurance Company	Plan Name	Name of Policy Holder (Insured's name) <input type="checkbox"/> Client <input type="checkbox"/> Other:		
Insured's ID #	Insured's Date of Birth	Insured's Employer		
Address for Claims	Claims Phone Number	Deductible	Copay	Amt pd to deductible

Other Relevant Information

Referral Source (Name and relationship to client)
Medications (name, dosage, frequency, purpose)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

→ Printed Name of client: _____

(if client is a minor)

→ Printed Name of parent/guardian: _____

SECTION B: Important Information - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will be giving your consent for my use and disclosure of your protected health care information. This information will be utilized solely for the rendering of mental health treatment and associated payment activities.

Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before deciding whether to sign this Consent. My Notice provides a description of the uses and disclosures I may make of your protected health information and of other important matters about your protected health information. A copy of my Notice of Privacy Practices will be provided upon request. I encourage you to read it carefully before signing this Consent.

As circumstances may dictate, and within the limits of the law, I reserve the right to change my Privacy Practices. If changes are implemented, they will be provided for your review. Said changes may apply to your Health Care Information which was previously obtained.

You may obtain a copy of my Notice of Privacy Practices, including any revisions of my Notice, at any time by contacting me.

Right to Revoke: You have the right to revoke this Consent at any time by giving me written notice of revocation submitted to the above address or Fax number. Please understand that revocation of this Consent will not affect any action I took in reliance on this Consent before I received your revocation.

By signing below I indicate that I have had full opportunity to read and consider the contents of this Consent form and this office's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I further acknowledge that I have, on behalf of myself and/or any minor or incapacitated dependents, read and understand this office's Notice of Privacy Practices.

→ Client (or parent/guardian) Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Please let me know if you would like a copy.

Julie Shewman, LPC
125 Christensen Drive, Ste. 2 Anchorage, AK 99501
Phone: (907) 538-4622 | Fax: (907) 868-8692
Julie@julieshewmanlpc.com

Electronic Communication Consent

Email communication can provide an efficient and effective way to communicate regarding issues that are non-emergent, non-urgent, and non-critical. Email can be used to request a non-emergent appointment, cancel a future appointment (at least one full business day in advance), share new information, or request information.

The following summarizes the information that you need to know in order to determine whether you wish to supplement your experience at my practice through electronic communications.

General Considerations

To the extent I am able, email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records. Standard email servers, such as Yahoo, Gmail, or Hotmail, are not secure which means that, although the accounts are password protected, the email messages are not encrypted. These messages can potentially be intercepted and read by unauthorized individuals. Your email will only be used as a means of communication between you and me, never for marketing or any other purpose.

Healthcare Office Responsibilities

Every attempt will be made to respond to your email message within 2 business days (Monday through Thursday, excluding holidays), unless I am out of the office for a vacation or illness. If you do not receive a response from me within 2 business days, please contact me by phone. Copies of the emails that you send me, and that I send you, may be incorporated into your records with my office. You are advised to retain copies for your files as well.

Client Responsibilities

Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For other emergent or time sensitive situations, you should contact me by phone. Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.

By signing below I acknowledge that I have read and understood the above description of the risks and responsibilities involved with electronic communications. I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

In consideration of my desire to use electronic communication, I hereby consent to electronic communication over non-secure email services. I have read and acknowledge the "Client's" responsibilities.

I understand that I may revoke my consent to communicate electronically at any time by notifying Julie Shewman, LPC, in writing. If I revoke consent, the revocation will have no effect on any actions Julie Shewman, LPC, has already taken in reliance on my consent.

I agree and release Julie Shewman, LPC, and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

→ **Authorized email address (please print):** _____

→ **Printed Client Name:** _____

→ **Client signature:** _____ **Date:** _____

Julie Shewman, LPC
125 Christensen Drive, Ste. 2 Anchorage, AK 99501
Phone: (907) 538-4622 | Fax: (907) 868-8692
Julie@julieshewmanlpc.com

I can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your service provider name. The appointment reminder service will not encrypt the messages. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted.

If you understand these risks and would like to receive an appointment reminder by email, I need you to confirm you accept responsibility for these risks and will not hold me responsible for any event that occurs after I send the message.

☐ **I would like to receive email appointment reminders at the following email address:**

→ **Authorized email address (please print):** _____

→ **Printed Client name:** _____

→ **Client signature:** _____ **Date:** _____

Julie Shewman, LPC
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Julie@julieshewmanlpc.com

CREDIT CARD AUTHORIZATON FORM

Please complete all fields. You may cancel this authorization at any time by contacting Julie Shewman, LPC. This authorization will remain in effect until cancelled for as long as you are engaging in services.

Please note the late cancellation fee/no show fee will be charged to this card on the date the services were to be rendered. Insurance does not cover this fee and will not be billed.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA

Printed Cardholder Name (as shown on card): _____

Card number: _____

Expiration Date (MMYY): _____

Card CVN# (3 digit code on back of card): _____

House or P.O. Box # where billing statement comes: _____

Zip Code where billing statement comes: _____

By signing below I authorize Julie Shewman, LLC to charge my credit card above for agreed upon services and (if applicable) the late cancellation/no show fee. I understand that my information will be retained on file for future transactions on my account.

Cardholder Signature: _____ Date: _____