SHANNON WEISE COUNSELING, LLC

2601 N. Front Street, STE 201 Harrisburg, PA 17110	Phone: 717-461-7933 Fax: 717-474-3452

CONSENT TO TREATMENT & PAYMENT POLICIES

FEES & PAYMENT: All fees are to be paid at the time of service. Shannon Weise Counseling, LLC reserves the right to postpone treatment to clients with balances over $100. Regular sessions are 45-50 minutes in length. Fees are for this time. Variations from this time (e.g., two sessions in one week, a longer session) will be billed accordingly. Fees are set up at the beginning of treatment. You will always be informed at least a month in advance of any fee increases.
Your psychotherapist may also charge for other professional services (this may include phone calls and text conversations) you may need.
You will be charged for between session phone calls lasting longer than 10 minutes on the following basis: 10-30 minutes: $65. 30-45 minutes: $110. 60 minutes: $130.
At this time phone sessions and Facetime/Skype are not billable to insurance. Sometime in the future telemed services may be billable to insurance.

Payment is due at the beginning of each session. We accept Cash, Checks and Visa/MasterCard/Discover/American Express. Cash or check is the preferred payment method. A $2 fee will be added to all credit card transactions. Checks are to be made out to Shannon Weise Counseling. There is no change available for cash payments. However, you will receive a credit on your account. A $30 service charge will be assessed for any checks returned by bank for insufficient funds. After any returned checks, Shannon Weise Counseling, LLC reserves the right to require all future payments be made in cash or with a credit card.

CANCELLATIONS REQUIRE 24 HOURS NOTICE: When an appointment is scheduled, that time is reserved specifically for you. You must provide a minimum of 24 hours' notice or you will be billed in full. The fee is $110 for a cancellation less than 24 hours. Phone sessions in place of in-person sessions are always available. We accept voicemails and text messages 24/7 at the phone number designated by your psychotherapist. Please do not email regarding cancellation.
You may only carry a balance for one week. Balances older than one week will be automatically billed to your credit card. Balances owed from previous visits are expected to be paid in full at the time of your appointment. Future sessions will not be scheduled unless all balances are paid in full.

PAYMENT:
By filling out the information below, you acknowledge that any outstanding balances will be automatically charged to your credit card. This will only be used in the situation of cancellations or outstanding balances. All information will be kept in your chart.

Card type:

Name on card:

Card number:

Security code:

Expiration date:

Signature:

_____Please charge all balances/cancellations directly to this credit card. Your Initials:_________

COLLECTIONS: Collection activity will be pursued when a balance is more than 60 days old and several attempts have been made to collect payment by mail via patient statements and letters. A $40 fee will be assessed to each account turned over to collection. Be advised that your confidentiality regarding billing information will automatically be waived if your account is turned over to a collection agency. If your account is in collections, any appointments you have scheduled will be cancelled and no further appointments will be made until the balance is paid in full. Shannon Weise Counseling, LLC reserves the right to bill in advance for scheduled appointments for those accounts that have previously been in collections.

INSURANCE BENEFITS & BILLING: Health insurance is a contract between you and your insurance company. For those companies with which we participate we will file claims as a courtesy to our clients. However, we cannot bill your insurance unless you have provided us with complete and accurate insurance information. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coinsurance, covered charges, secondary insurance, etc. other than to supply information as necessary. Although our billing department will contact your insurance company by website and/or telephone to obtain the specifics of your insurance plan, it is your responsibility to be aware of your plan's annual visit limits, deductible amounts, percentage of charges your insurance will pay and non-covered services. Any charged amount not covered by your insurance will be your responsibility to pay. Shannon Weise Counseling, LLC ordinarily does not bill either secondary insurance or those companies with whom we do not participate. You will be provided with an invoice for services that contain all information necessary for you to bill your claims.

MINORS & SHARED CUSTODY: In the case of divorced or separated parents, the person accompanying the child or children is responsible for payment at the time of service.

EMERGENCY CALLS: SHANNON WEISE COUNSELING, LLC DOES NOT PROVIDE ON-CALL TELEPHONE SERVICE. IN AN EMERGENCY YOU MUST GO TO THE EMERGENCY ROOM OR CALL 911. NEVER USE EMAIL OR TEXT TO COMMUNICATE WITH YOUR THERAPIST DURING AN EMERGENCY.

CONFIDENTIALITY:
The law protects the privacy of all communication between a client and a psychotherapist. In most situations, the psychotherapist can only release information if you sign a consent form.
Your signature on this Agreement provides consent for these activities:

Obtaining the appropriate kind and level of help if you threaten to harm yourself. This can involve contacting 911, a family member, and/or others who can help provide protection. Consulting with other mental health or medical professionals regarding your situation. During these consults, every precaution is taken to protect your identity. The other professionals are also legally obligated to keep the information confidential. If you do not object, your psychotherapist will not inform you of these consults unless they feel it is important to your work together. E-mailing you regarding new services. Disclosing required information to a collection agency to collect overdue fees.

Disclosing Personal Health Information to managed care companies regarding a claim you submitted. Disclosing Personal Health Information to managed care companies for the purpose of payment.

There are situations in which the psychotherapist is permitted or required by law to disclose information without either your consent or authorization:
If you are involved in a legal proceeding and the psychotherapist is served with a court order for information regarding your diagnosis and treatment. If a government agency requests information for health oversight activities. If you file a lawsuit or complaint against the psychotherapist or practice, the psychotherapist may disclose information about you as part of their defense. If the psychotherapist is being compensated for providing treatment as a result of a worker's compensation claim that you filed. Upon the appropriate request, the psychotherapist will need to provide information for utilization review purposes.
In situations in which the psychotherapist believes it is necessary to attempt to protect others from harm, the psychotherapist may need to reveal information about you and your treatment. Your consent or authorization to release information is not needed in these situations:
Psychologists and Social Workers are considered mandated reporters of child and elder abuse. If there is reason to suspect child or elder abuse and/or neglect, the psychologist/social worker is mandated to file a report with the police and/or the necessary protective agencies. Once a report is filed, the psychologist/social worker may be required to provide additional information. If a client communicates a threat of physical violence against an identifiable third person (or the community) and the client has the apparent intent and ability to carry out that threat in the near future, the psychologist/social worker has to take protective actions. These actions include notifying the potential victim (or, if the victim is a minor, his/her parents and the county Department of Social Services), contacting the police, and/or seeking psychiatric hospitalization for the client.

I CONSENT TO RECEIVE TREATMENT for therapeutic/psychological services through SHANNON WEISE COUNSELING, LLC. This is to certify that I have read this document outlining practice policies regarding: services, payment, insurance, cancellations, psychotherapist availability, and privacy. I understand them and agree to comply with the policies and procedures described in this document.

Signature of Responsible Party (patient if 14 or older):	Date:
Print Patient Name:	