

Eric Leever, LMHC

Client Information Sheet

Date _____

NAME (of client) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ CELL _____

E-MAIL: _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

STATUS: SINGLE MARRIED OTHER MALE FEMALE

EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

IS CONDITION RELATED TO:

EMPLOYMENT: YES NO IF YES: CURRENT _____ PREVIOUS _____

AUTO ACCIDENT: YES NO STATE OTHER ACCIDENT: YES NO

INSURED'S NAME _____

(if you, the client are also the insured, write: Same as Above. If you, the client are not the insured, please fill in)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____

DATE OF BIRTH _____ SOCIAL SECURITY# _____

OFFICE USE ONLY: Eric Leever, LMHC

Dx: _____

CPT: _____

Fee: _____ FIRST DATE OF SERVICE: _____

BILLING PRACTICES ACKNOWLEDGEMENT/FEE AGREEMENT

IDENTIFY SERVICE(S):

All Services

IDENTIFY CHARGE FOR SERVICE(S):

Per Insurance Company Schedule or

Private Pay rate (\$90 std. discount)

Actual charges for services will be based upon the LMHC published fee schedule. LMHC does not deny services to individuals unable to pay full fee. Charges will be assessed based upon a review of the individual's or family's circumstances.

FEE AGREEMENT

Actual charges for services will be based upon the above fee schedule with the sliding scale fee applied where applicable. If you do not have insurance, you understand that fees for the treatment services will be 100 % of the fees listed above. _____INITIAL

ASSIGNMENT OF BENEFITS (insurance only)

I authorize payment of Blue Cross / Blue Shield, Medicaid, and other Third Party Payors to process my insurance claim for services rendered. _____INITIAL

RELEASE INFORMATION (insurance only)

I authorize the release of any medical or other information necessary to Blue Cross / Blue Shield, Medicaid, and any other third Party Payor to process my insurance claim for services rendered. _____INITIAL

1st CLIENT SIGNATURE

DATE

2nd CLIENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE (if required)

DATE

Therapist – Eric Leever, LMHC

DATE

INFORMED CONSENT AND AGREEMENT TO PARTICIPATE IN SERVICES PROVIDED BY
LEEVER MENTAL HEALTH COUNSELING

I, _____ agree to participate in services provided by Leever Mental Health Counseling ("LMHC") on behalf of

(check one or both) ___ Myself ___ The following minor child(ren):

Minor child _____
(name) (date of birth)

Minor child _____
(name) (date of birth)

Minor child _____
(name) (date of birth)

Minor child _____
(name) (date of birth)

I understand that services I/we/they participate in may last up to ___12___ months and that during that time I/we/they will be visited by or will visit with a mental health therapist.

I agree to cooperate with this professional, to take an active part in the development of my/our/their service plan, and to work toward my/our/their goals by doing the tasks outlined in the service plan in order to accomplish my/our/their stated objectives.

I understand that I have a legal right to privilege of confidentiality for all therapeutic information with the following exceptions:

- (1) When the therapist has a suspicion of abuse of a child, an elderly person, or a disabled person.
- (2) When the therapist has reason to believe that a known individual is under imminent threat of harm or death.
- (3) When records are required to be released by a court order.
- (4) When a client gives written and verbal authorization to release information to a specific third party.
- (5) When records are requested by a legal guardian of a client.

This consent or authorization for release of information shall be effective the date of signature and shall expire:
___ ninety (90) days from the date of signature for a one time release of information OR
___ one (1) year from the date of signature for ongoing service provision.

Signature of Adult Client or Guardian DATE

Therapist DATE

Acknowledgment of Receipt of Billing Practices
Eric Leever, LMHC

I acknowledge the fact that all information, pertinent to billing, is being given to **JoAnn McGuire. 772-777-2850.**

By signing this, I acknowledge that I have received a copy of this statement regarding billing practice for **Eric Leever, LMHC.**

Name of Client or Adult: _____

Signature of Client or Adult: _____ **Date:** _____

Eric Leever, LMHC

Signature of Witness: _____

Acknowledgment of Cancellation/No-Show Policy
Eric Leever, LMHC

I agree to notify Eric Leever, LMHC of cancellation of appointment prior to 24 hours before the appointment time.

Notification of cancellation within 24 hours or failing to show up for an appointment is considered a no-show. If a client no-shows two times within one year, that client will be given the option of discharge and referral to another mental health provider, or reimbursement for the appointment missed. Please note that some insurance companies do not allow no-show appointments and in this case the client will be discharged and referred to another mental health provider. The fee for a no-show appointment is \$50 and will be charged on the second missed appointment.

Notifications must be in the form of a phone call to 772-284-6030. This number does not accept text messages. Exceptions for unavoidable occurrences such as family emergency, illness, last minute car trouble, etc. may be made at Leever Mental Health Counseling's discretion.

Name of Client or Adult: _____

Signature of Client or Adult: _____ **Date:** _____

Eric Leever, LMHC

Signature of Witness: _____