SUNSTONE HEALTH & WELLNESS
1700 W. SMITH VALLEY RD., SUITE B4, GREENWOOD, IN 46142
PHONE: (317) 886-1000 FAX: (317) 886-1001

Client Information

Client Name_____ DOB_____

Parents names if minor_____

Address_____

City_____ Zip_____

Home #_____ Cell # _____

Email address_____

Employer_____ Phone_____

Employer Address_____

Emergency Contact_____ Phone_____

How you found Sunstone Health & Wellness_____

Referred by _____

Brief description of your concern_____

_____

_____

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CREDIT CARD AUTHORIZATION FORM

The undersigned hereby authorizes Lacey J. Rentschler, MSW, LCSW, of Sunstone Health & Wellness, to charge my credit card (provided below) for the amount of the therapy session if there is an outstanding balance more than 30 days after issuance of an invoice.

A current credit card number must be on file at all times, regardless of your preferred method of payment.

Your card will not be charged if you pay by cash or check by the time your payment is due.

The credit card to remain on file is:

1. Choose one: MasterCard ☐ Visa ☐ AMEX ☐ Discover ☐
2. Card Number: _____
3. Expiration Date: _____
4. Security Code: _____
5. Name as appears on the card: _____
6. Billing Address with zip code: _____
7. Signature of card holder: _____

The Undersigned understands and agrees to be bound to such agreements as outlined in this document.
Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

SIGNATURE: _____

PRINT NAME: _____

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

Sunstone Health & Wellness
Phone: 317-886-1000

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CLIENT INFORMATION AND POLICY STATEMENT

Please read the following important information. If you have questions, you may discuss them with your therapist.

CONFIDENTIALITY Federal HIPAA and Indiana law require that issues discussed with a therapist will be confidential. The therapist will not discuss the information you reveal with anyone without a signed authorization form from you. If information is requested from your therapist by a third party, e.g. family members, schools, or other mental health professionals, it would be helpful if you would discuss this with your therapist as soon as possible. If at any point the therapist believes it would be useful to confer with other professionals, you will be asked to grant permission and to sign an authorization form. **PLEASE INITIAL**_____

EXCEPTIONS TO CONFIDENTIALITY Indiana state law and professional ethics codes require therapists to maintain confidentiality except in the following situations: 1) When threat to injure or kill oneself is communicated to the therapist. 2) If there is suspected child abuse, elder abuse, or dependent adult abuse. 3) A situation in which serious threat to a reasonably well-identified victim is communicated to the therapist. 4) Instances where the court or government subpoena records. **PLEASE INITIAL**_____

ELECTRONIC COMMUNICATION Cell phones, emails, and faxes may be used within the scope of treatment by mutual choice between you and your therapist. While Sunstone Health & Wellness takes every available safeguard to provide safe electronic communication, all electronic communication has the potential to compromise confidentiality. **PLEASE INITIAL**_____

TREATMENT Evaluation may include psychological and/or psychosocial evaluations. Treatment may consist of psychotherapy, counseling, and other modes of treatment available and tailored to your needs, including hospitalization, if required. Your consent does not waive your civil rights and you may reserve the right to decline treatment against professional advice.

You have the continuing right to an explanation of the procedure to be administered. Understand that there is no assurance that you will feel better. Because psychotherapy is a cooperative effort between you and your therapist, you must work with your therapist in a cooperative manner to resolve your difficulties. During the course of your treatment, material will be discussed which will be upsetting in nature and this may be necessary to help you resolve your problems. **PLEASE INITIAL**_____

APPOINTMENTS Treatment usually depends on regularly scheduled appointments. Both you and your therapist will evaluate the progress of your therapy periodically to determine the need for further appointments. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the therapist's ethical responsibility to end therapy when it is reasonably clear that you are no longer benefiting from treatment. **PLEASE INITIAL**_____

CANCELLATIONS If you find it necessary to cancel a scheduled appointment, 24 hours notice is required. With less than 24 hours advance notice, you will be responsible for the full amount of your regular fee. Please note that this is an out of pocket expense, as insurance companies will not cover missed sessions. You may be asked for a credit card number in order to schedule an initial consultation. In case of a serious emergency, school closings due to weather or illness, if you notify us immediately, we will reschedule your appointment without additional charge**. PLEASE INITIAL**_____

PAYMENT General fee schedule is $125.00 for initial consultation, $100.00 for one-hour individual or family sessions, $150.00 for 90 minute individual or family sessions, and $45.00 for reports or clinical summary. Full payment is expected before or at time of service. Payment is accepted in the form of cash, check, or Visa, MasterCard, and Discover debit or credit cards. A complete receipt will be provided to so you can submit for insurance reimbursement directly to you. **PLEASE INITIAL**_____

INSURANCE Sunstone Health & Wellness does not accept insurance benefits. Please check with your insurance company to determine if you can submit your expenses to receive out of network benefits directly. It is your responsibility to submit insurance claims yourself. Sunstone Counseling Center believes it may be to our clients benefit not to accept insurance benefits for the following reasons:

PRIVACY & CONTROL Insurance companies ask for detailed clinical information about you and this is kept in their computer database. We have not control over how this information is used and who has access to it. We cannot guarantee confidentiality on any information released to an insurance company. Insurance companies require that a *PSYCHOLOGICAL DIAGNOSIS* be submitted and your treatment plan and number of sessions allowed can be determined by the insurance based on that diagnosis. The diagnostic code becomes part of your health information on file with your insurance company. **PLEASE INITIAL**_____

EMERGENCIES Sunstone Health & Wellness offers outpatient counseling services only. If you or your loved one requires more intensive treatment, call your insurance company for a list of approved facilities or hospitals that are covered by your plan. If you are having a crisis or emergency that requires immediate attention outside of normal business hours or you are unable to reach your therapist by phone, proceed to the nearest hospital or emergency room. **PLEASE INITIAL**_____

Consent to receive all services, insurance correspondence, referral source contact, and receipt of privacy practices:

By signing below, I consent to participate in counseling services offered by Sunstone Health & Wellness. I understand I am consenting and agreeing only to those services that Sunstone Health & Wellness associates are qualified to provide within the scope of license, certification and training as, or under the care of a Licensed Clinical Social Worker or Licensed Marriage and Family Therapist.

By signing below I acknowledge that I have received a copy of Sunstone Health & Wellness' Notice of Privacy Practices**.**

SUNSTONE HEALTH & WELLNESS

By signing below, I acknowledge that I have been informed of my rights and responsibilities and have read and understand the administrative polices of Sunstone Health & Wellness

_____ _____

Signature of client Date

_____ _____

Signature of parent or legal guardian Date

_____ _____

Signature of Therapist Date