

ALLYN D ROBB JR. EDS NCC LPC

Licensed Professional Counselor

Emerald Isle Counseling

Judy Watterson Practice Manager

Dear Patient:

Please find the paperwork required for your upcoming appointment at our offices with Emerald Isle Counseling, Inc. Paperwork should be completed prior to appointment.

In addition to this paperwork, please bring your insurance card and identification card; whichever applies. It is necessary that we have copies for our files.

Important: If you have not contacted your insurance company, please do so to determine if a referral and preauthorization is needed. Additionally, find out if your deductible has been met and if copay is applicable for services rendered.

Practice policy requires us to collect copays or deductibles the day of the appointment.

If you are cash pay client, please be prepared to pay in full at the time of service.

Personal checks and credit cards (including processing fee) are accepted.

On the day of your appointment, please report to our office and wait in the assigned area. Your therapist will meet you there.

Thank you for allowing us to be your service provider and we look forward to meeting you.

Respectfully,

Judy A Watterson

Practice Manager

Emerald Isle Counseling

300 Oak St Su 203
St Simons Island Ga
31522

PHONE 912-268-4750
FAX 888-837-0039
E-MAIL info@emeraldislecounseling.com
WEB SITE www.emeraldislecounseling.com

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Dear Client:

Welcome to Emerald Isle Counseling. We are pleased you selected our practice as your service provider. To receive the full benefits of your counseling experience, we strongly suggest that you:

- A. Attend your sessions regularly. Be committed to your program
- B. Be honest with yourself and your therapist about concerns that led you to therapy
- C. Establish realistic goals and outcomes
- D. Regularly discuss your progress with your therapist
- E. Modify your goals as needed
- F. Be well prepared for your sessions. Do your homework
- G. Be willing to honestly evaluate your progress or lack thereof
- H. Participate honestly and fully

Counseling is a journey of self-examination and discovery. During this journey, if you are willing to do the work, you will build yourself as a person, you will enhance your emotional awareness, you will see personal growth and you will learn how to constructively deal with non-productive or self-destructive thoughts, emotions and behaviors. Essentially you will be acquiring a new set of tools to build a healthier and happier life.

Good Luck.

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Client Information

Dear Client: (type or print clearly)

Name _____ DOB _____ Gender _____

Address _____ City _____ Zip _____

Home Phone _____ Mobile Phone _____

Social Security Number _____

Emergency Contact Name _____ Number _____

Relation _____

Insurance Company _____ Policy _____

Group Number _____ Group Name _____

Company Address _____ Provider Phone # _____

Deductible _____ Co-pay _____

Name of Insured _____ Relation _____ DOB _____

Appointment Reminders: The preferred method of appointment reminders is email 24 hours prior to appointment. However, if you do not have regular access to email, please provide a PREFERRED phone number.

Cancellations of less than a 24 hr notice and/or missed appointments will incur a \$50 No Show Fee.

Active Email Address _____ @ _____

Preferred Phone Number _____ (mobile or home)

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Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name _____ Date _____

Date of Birth _____ Primary Care Physician _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor _____ Therapist's Phone _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

- | | | |
|--|--|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | |
| <input type="checkbox"/> Decreased libido | | |

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? () Yes () No.

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? () Yes () No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies _____

Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name

Total Daily Dosage

Estimated Start Date

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

Current medical problems: _____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

Have you ever had an EKG? () Yes () No If yes, when _____ .

Was the EKG () normal () abnormal or () unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? () Yes () No. Are you planning to get pregnant in the near future? () Yes () No

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? () Yes () No

Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease -----	()	()	_____
Anemia-----	()	()	_____
Liver Disease -----	()	()	_____
Chronic Fatigue -----	()	()	_____
Kidney Disease -----	()	()	_____
Diabetes -----	()	()	_____
Asthma/respiratory problems -----	()	()	_____
Stomach or intestinal problems ---	()	()	_____
Cancer (type) -----	()	()	_____
Fibromyalgia -----	()	()	_____
Heart Disease -----	()	()	_____
Epilepsy or seizures -----	()	()	_____
Chronic Pain -----	()	()	_____
High Cholesterol -----	()	()	_____
High blood pressure-----	()	()	_____
Head trauma -----	()	()	_____
Liver problems -----	()	()	_____
Other -----	()	()	_____

Is there any additional personal or family medical history? () Yes () No If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History:

Outpatient treatment () Yes () No If yes, Please describe when, by whom, and nature of treatment.

Reason

Dates Treated

By Whom

Psychiatric Hospitalization () Yes () No If yes, describe for what reason, when and where.

Reason

Date Hospitalized

Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates

Dosage

Response/Side-Effects

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortriptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine) _____

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Other _____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

Antianxiety medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

Your Exercise Level:

Do you exercise regularly? () Yes () No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	() Yes () No	Schizophrenia	() Yes () No
Depression	() Yes () No	Post-traumatic stress	() Yes () No
Anxiety	() Yes () No	Alcohol abuse	() Yes () No
Anger	() Yes () No	Other substance abuse	() Yes () No
Suicide	() Yes () No	Violence	() Yes () No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? () Yes () No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? () Yes () No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? () Yes () No

Have people annoyed you by criticizing your drinking or drug use? () Yes () No

Have you ever felt bad or guilty about your drinking or drug use? () Yes () No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? () Yes () No

Do you think you may have a problem with alcohol or drug use? () Yes () No

Have you used any street drugs in the past 3 months? () Yes () No

If yes, which ones? _____

Have you ever abused prescription medication? () Yes () No

If yes, which ones and for how long? _____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	()	()	_____
Cocaine	()	()	_____
Stimulants (pills)	()	()	_____
Heroin	()	()	_____
LSD or Hallucinogens	()	()	_____
Marijuana	()	()	_____
Pain killers (not as prescribed)	()	()	_____
Methadone	()	()	_____
Tranquilizer/sleeping pills	()	()	_____
Alcohol	()	()	_____
Ecstasy	()	()	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? () Yes () No

Currently? () Yes () No How many packs per day on average? _____ How many years? _____

In the past? () Yes () No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? () Yes () No In the past? () Yes () No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? () Yes () No Where did you grow up? _____

List your siblings and their ages: _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? () Yes () No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? () Yes () No.

Please describe when, where and by whom: _____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: () Working () Student () Unemployed () Disabled () Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge () Yes () No Other type discharge _____

Relationship History and Current Family:

Are you currently: () Married () Partnered () Divorced () Single () Widowed

How long? _____

If not married, are you currently in a relationship? () Yes () No If yes, how long? _____

Are you sexually active? () Yes () No

How would you identify your sexual orientation?

() straight/heterosexual () lesbian/gay/homosexual () bisexual () transsexual

() unsure/questioning () asexual () other () prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? () Yes () No. If so, how many? _____

How long? _____

Do you have children? () Yes () No If yes, list ages and gender: _____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? () Yes () No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? () more helpful () stressful

Is there anything else that you would like us to know?

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Emerald Isle Counseling LLC

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Emerald Isle Counseling appreciates the confidence you have shown in choosing us to provide for your mental health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Fee Schedule

			Average Session Timing
90791	Therapy Intake	195.00	53 min
90837	Ind. Counseling	145.00	53 min
90834	Ind. Counseling	135.00	45 min
90847	Family Counseling	145.00	53 min
	Telephone/Skype Sessions	145.00	53 min

Please call office for any additional quotes.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

We accept cash, checks or charge cards (plus a processing fee of 2.75%) as payment. Any returned checks will have a NSF fee of \$20 per check and the full account balance plus any NSF fees will be due for payment in full immediately.

I have read the above policy regarding my financial responsibility to Emerald Isle Counseling LLC, for providing mental health services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Emerald Isle Counseling LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Emerald Isle Counseling LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Emerald Isle Counseling LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call and cancel 24 hours prior to your appointment. Failure to do so may result in a \$50.00 No Show fee.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Emerald Isle Counseling LLC will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered. I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

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Judy Watterson Practice Manager

Credit Card Voucher Circle One: VISA MASTER CARD DISCOVERY

Name As It Appears on Credit Card: _____

Credit Card Account Number: _____

Credit Card Billing Address: _____

Expiration Month/Day/Year: _____

Three Digit Security Code: _____

Amount Authorized: _____

Date of Service: _____

Cardholder Signature: _____

Keep Card Information On File: Yes__ No__ Initial__

Office use only: Keyed Date _____ Initials _____

Notes:

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Consent for Release of Information

I, _____ DOB _____

Authorize _____

To Release the following information from my medical, psychiatric and substance abuse records (if applicable):

- | | |
|---|--|
| <input type="checkbox"/> discharge summary | <input type="checkbox"/> psychological testing |
| <input type="checkbox"/> psychiatric evaluation | <input type="checkbox"/> neurological testing |
| <input type="checkbox"/> medical history/physical | <input type="checkbox"/> diagnoses |
| <input type="checkbox"/> consultations | <input type="checkbox"/> biosocial history and assessments |
| <input type="checkbox"/> lab reports | <input type="checkbox"/> progress notes |
| <input type="checkbox"/> correspondence | <input type="checkbox"/> legal documentation |

Check here to authorize all of the above: initial

To be sent to:

Emerald Isle Counseling
545 Oglethorpe Avenue Suite 204
St Simons Island Ga 31522
912-268-4750 Office 888-837-0039 Fax

For the purpose of: Continuity of Care and Transference of Records

Information released is not to be further disclosed or used for any other purpose than that stated in this authorization. It is understood that I have the right to revoke this consent in writing. I have the right to inspect and copy the information released.

This authorization is valid until _____.

Expires one year from date signed unless otherwise indicated.

Patient's Signature: _____ Date _____

Parent Signature: _____ Date _____

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CLIENT RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home? (circle one) YES NO. May we contact you at work? YES NO. May we contact you by cell phone? YES NO. Where may we contact you? _____

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment or health care operational purposes or that we shared with you or your family or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact us personally and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

Patient/Guarantor Signature _____ Date _____

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: Today's Date (see below)

Emerald Isle Counseling, Inc., has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent
There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Georgia State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Patient /Guarantor Signature _____ Date _____

Emerald Isles Counseling LLC

FINANCIAL INFORMATION ADDENDUM
FEES INCURRED FOR LEGAL AND COURT SERVICES

Preparation time (including submission of records): 125.00 per hour

Phone calls: 125.00 per hour

Depositions: 175.00 per hour

Time required in giving testimony: 175.00 per hour

Mileage: \$0.55 per mile

Time away from office due to depositions or testimony: 175.00 per hour

All attorney fees and costs incurred by the therapist as a result of the legal action.

Filing a document with the court: \$100

The minimum charge for a court appearance: 750.00 ½ day minimum 1500.00 full day

Compliance and program completion documentation 100.00

