Emerald Isle Counseling

Allyn D Robb Jr. EDS, NCC, LPC Genie Nall LPC Denise Schuster LPC Mary Barns LPC
Aubrie Reedy LPC Alison Jimenez LPC Michael Gilliard LAPC Jennifer Sears LAPC
Aaron Coots LCSW

Dear Patient:

Please find the paperwork required for your upcoming appointment 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. 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 co-pay is applicable for services rendered.
Practice policy requires us to collect co-pays 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
WEBSITE 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 will 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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Aaron Coots LCSW

Judy Watterson Practice Manager

Practice Protocols

***Phone Contacts*:**	**912-268-4750**	***Judy Watterson/Christina McCormick***
Scheduling: **All scheduling/Changes Cancellations**	**912-268-4750**	***Judy Watterson-practicemanageremeraldisle@gmail.com*** ***Christina McCormick cmccormickeic@gmail.com***
Billing-Insurance:	**912-268-4750**	***Judy Watterson-practicemanageremeraldisle@gmail.com*** ***Christina McCormick cmccormickeic@gmail.com***

Financial:* Please be prepared to make co-pay or deductible payment at time of service. Be sure to contact your insurance company for information. Cancellation fee (less than 24 hours notice) is $50.00

Dear Clients:
We are thrilled you selected us to be your service provider; Emerald Isle Counseling. We will rely on your email, voicemail and other means of electronic media when contacting you. Please utilize our website for contact whenever possible. Phone calls and messages will be addressed in 24 hours. Matters of an urgent nature should be so identified: Follow phone message with an email to Practice Manager when possible.
Thank You

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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. Who my we thank for referring you to us? _____. 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)

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

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

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, non-psychiatric 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 (nortrptyline) _____

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 3%) 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.

Unpaid balances with be charged 1 1/2 % Finance Charge added monthly after 30 days which is an annual Percentage Rate of 18%. Balances over 60 days owed will be turned over to a collection agency and any collection/processing fees will be patient responsibility.

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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Circle One: **AMEX** **DISCOVERY** **MASTERCARD** **VISA**

Name As It Appears on Credit Card: _____

Credit Card Account Number: _____

Credit Card Billing Zip Code: _____

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):

__Discharge summary
__Psychiatric evaluation
__Medical history/physical
__Consultations
__Lab reports
__Correspondence
__ Psychological testing
__Neurological testing
__Diagnoses
__Biosocial history and assessments
__Progress notes
__Legal documentation

_x__ Check here to authorize all of the above: ___initial

To be sent to: Billing Office Emerald Isle Counseling
302 Magnolia Street
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_____

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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_____

HIPAA 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 INFORMATIION. 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