Connie Bonner-Britt, MA LMHC
360-542-6895
connie@selftimeout.org
FAX 866-492-5137
924 South 11th Street, Mount Vernon, WA 98274

DISCOUNT (NO INSURANCE) ENROLLMENT PACKET

REQUIREMENTS TO UNDERSTAND AND DECISIONS TO MAKE BEFORE ENROLLING FOR SERVICES WITH CONNIE BONNER-BRITT, MA, LMHC.

Since Connie does not have staff to do things like check your insurance, send out monthly billings or deal with collection agencies and since she wants to continue charging much lower than average fees... she needs you to understand her payment rules very clearly BEFORE you make a decision to schedule your first session:

1. YOUR CREDIT CARD INFORMATION AND YOUR AUTHORIZING SIGNATURE MUST BE ON FILE PRIOR TO SCHEDULING THE FIRST SESSION.

NOTE: You can sign up for PayPal BillMeLater and get six months to pay without interest.

2. PLEASE CHOOSE BETWEEN 2a OR 2b BELOW

2a. DISCOUNTED (NO INSURANCE) RATES

Fees for service with no insurance billing:

- **INTAKE:** $110.00
- **REGULAR SESSIONS:** $75.00.
- If you need a reduced fee please call me now at: 360-542-6895
- All Fees for service will be paid in full before or at the beginning of each session (Cash, credit card, or check.) NO EXCEPTIONS.
- If you have insurance you can choose to apply to your insurer for reimbursement. Please ask me for a Statement of your account.

Go to the **FORMS** button and choose:
DISCOUNT ENROLLMENT PACKET

2b. INSURANCE BILLING RATES

Fees for service including insurance billing:

- **INTAKE:** $140.00
- **REGULAR SESSIONS:** $100.00.
- I am willing to bill some insurance companies, however once I bill your insurance you are responsible to pay in full for all services at the above rates. (Based upon my agreement with your insurer's "contract allowables" policy.)
- I will bill PRIMARY INSURANCE ONLY. If you intend to submit reimbursement forms to your SECONDARY insurer, please ask me for a Statement of your account.
- When I get your insurance company's statement (EOB) which will include their payment to me, I will charge your credit card for any remaining unpaid balance which might include Co-pay and Deductibles.
- If I do not get a prompt response from your insurance company, I will charge your credit card for any remaining unpaid balance. You can then seek insurance reimbursement yourself. Please ask me for a Statement of your account.

Go to the **FORMS** button and choose:
INSURANCE BILLING ENROLLMENT PACKET

4. NO SHOW AND LATE CANCELLATION POLICY

- When you and I schedule a therapy session we are both making a commitment of our time.
- No-shows and Late Cancellations (24 hours) for first or subsequent sessions will be charged **$60.00** against your credit card.

5. FILLING OUT AND SUBMITTING YOUR ENROLLMENT PACKET

If you need an Enrollment Packet have questions call Connie at: 360-542-6895

1. Choose and print out the Enrollment Packet your prefer. (Or call us and we will send you the packet.)
2. Fill in the blanks on Page 1.
3. Provide your signature in the "CREDIT CARD INFORMATION" section.
4. If you are using your insurance make clear copies of both sides of your insurance card and include them in your packet.
5. Fill in the "CLIENT INFORMATION" section. Fill in the "PARENT or GUARDIAN" if needed.
6. Provide "Client or Guardian" signatures and dates.
7. Read the "DISCLOSURE STATEMENT" . Provide signatures and dates.
8. Mail, Email or Fax the packet following the instructions provided.
9. Chuck will call you to set up your first session as soon as he gets the completed packet.
10. **Please be sure to bring your Original Signed Packet to the first session so Connie can co-sign and we can make copies.**

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DISCOUNT (NO INSURANCE) ENROLLMENT PACKET

WELCOME TO OUR SERVICES

YOU HAVE CHOSEN TO ASK CONNIE BONNER-BRITT TO SCHEDULE THERAPY SESSIONS.

Your credit card information and your authorizing signature **must be on file prior to scheduling the first session**. See below.

PRIVATE PAY BILLING POLICY

FEES FOR SERVICE AND PAYMENT RULES:

- **INTAKE:** $110.00
- **REGULAR SESSIONS:** $75.00.
- If you need a reduced fee please call me now at:
  360-542-6895
- All Fees for Service will be paid in full before or at the beginning of each session (Cash, credit card, or check.) NO EXCEPTIONS.
- If you have insurance you can choose to apply to your insurer for reimbursement. Please ask me for a Statement of your account.

NO SHOW AND LATE CANCELLATION POLICY

- No-shows and Late Cancellations (24 hours) for first or subsequent sessions will be charged **$60.00** against your credit card.
- Coming to the session without payment or cancelling at the time of the session, will be charged against your credit card as a no show. (Including the first session.)

ALL PERSONAL AND CREDIT CARD INFORMATION IS CONFIDENTIAL.

I AGREE TO PAY $**_____ before the first (Intake) session and **$_____ before each subsequent session.

SEVEN STEPS TO ENROLL FOR SERVICES:

1. PROVIDE YOUR CREDIT CARD INFORMATION

We need your credit card information and your authorizing signature **on file prior to scheduling the first session**.

2. FEES, COPAY AND DEDUCTIBLE NOTIFICATION:

YOU are responsible to pay for all session fees, no-show and late cancellation charges at the rates stated above:

WHATEVER YOU OWE THAT YOU DO NOT PAY AT THE SESSION WILL BE CHARGED TO YOUR CREDIT CARD.

CHECK YOUR CARD TYPE:	DISCOVER / MasterCard / VISA / American Express Card / PayPal					**CARD HOLDER NAME AS IT IS ON THE CARD:**
	☐	☐	☐	☐	☐	
CARD NUMBER:				**EXPIRATION:**	**MONTH:** **YEAR:**	**CVC CODE:**
ACCOUNT BILLING ADDRESS:	**STREET:**			**CITY:**		
I authorize Connie Bonner-Britt to charge the above credit card account for balances not covered by insurance.	SIGNATURE:			**STATE:**	**ZIP:**	

No charge will be made to your credit card unless there is an actual session, no-show or late cancellation and an actual balance.

3. PROVIDE THE FOLLOWING INFORMATION TO MEET STATE INFORMATION AND INSURANCE REQUIREMENTS:

FILE NAME CLIENT

Name_____ Date Of Birth_____-_____-_____ Age_____ Gender M or F

Address_____ City_____ State_____ Zip_____

Home_____-_____-_____ Work_____-_____-_____ Mobile_____-_____-_____

SSN _____-_____-_____ EMAIL ADDRESS: _____

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PARENT or GUARDIAN

Name_____ Date Of Birth_____-_____-_____ Age_____ Gender M or F

Address_____ City_____ State_____ Zip_____

Home_____-_____-_____ Work_____-_____-_____ Mobile_____-_____-_____

SSN _____-_____-_____ EMAIL ADDRESS: _____

4. PROVIDE SIGNATURES COMMITTING TO PAY FEES FOR SCHEDULING AND RECEIVING SERVICES.

I understand that by scheduling any session with Connie Bonner-Britt, MA, LMHC, and signing below that I am committed to pay the fees detailed above prior to the service.

Client or Guardian:_____**Date**_____-_____-_____

Client or Guardian:_____**Date**_____-_____-_____

Connie bonner-Britt, MA. LMHC_____ **Date**_____-_____-_____

5: MAIL / FAX / OR EMAIL THIS 2 PAGE FORM TO:

Connie Bonner-Britt, MA, LMHC
924 South 11th Street
Mount Vernon, WA 98274
or
FAX a .pdf file to: 866-492-5137
or
EMAIL a .pdf file to: connie@selftimeout.org

7. CHUCK WILL CALL YOU TO SET UP YOUR INTAKE SESSION.

PLEASE BRING THE ORIGINAL, SIGNED, TWO PAGE FORM TO YOUR FIRST SESSION SO THAT CONNIE CAN CO-SIGN IT AND MAKE COPIES FOR YOU TO TAKE HOME.

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DISCLOSURE STATEMENT

We have agreed to do important work together. I have designed this agreement to establish a safe structure for us and also to conform to Washington State Regulations. This structure, along with established professional ethics, protects our work and helps to make our relationship a safe place for growth and change. Please read the following carefully. If, for any reason, you have difficulty understanding any part of it please ask for assistance.

CLIENT RIGHTS:

- You have the right and the responsibility to control your own therapy.
- You have the right to choose a counselor that best suits your needs.
- You have the right to privacy, and information shared during the therapy process will remain confidential unless a signed release is obtained. (See exceptions below.)
- You have the right to ask questions at any time. I will do my best to be responsive.

Therapists practicing counseling for a fee must be registered or certified in accordance with the Counselor Credentialing Act with the Department of Health for the protection of the public health and safety. This empowers you with a complaint process against counselors who would commit acts of unprofessional conduct. Licensing of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If you believe I have violated my responsibilities as your therapist, you can contact your local law enforcement agency or the State of Washington Department of Health at (360) 664-9098.

CONFIDENTIALITY:

Under the law, I will disclose confidential information in the following situations:

- When there is reason to suspect the occurrence of child abuse or neglect.
- When there is a clear threat to do serious bodily harm to self or others.
- To a court under court order.
- In the event that you bring charges against me.
- To my office manager, Skagit Medical Billing, for the purpose of record keeping and billing. Skagit Medical Billing has signed a confidentiality statement, which is on file in my office.
- When necessary to insure best practice I will seek consultation from other qualified professionals who are also bound by and respect your right to confidentiality.

COUNSELING GOALS:

The goal is **Voluntary** change. You can choose to change the way you think, and/or behave. It is possible that you may "get worse before you get better." Some experience this as they work at improving. For support with Women's issues you may choose to attend my Women's Circle.

TREATMENT PROVIDED:

I am trained and licensed to provide individual, group and family therapy. I have a Masters Degree in Human Development, and over 20 years experience in the field. I do not discriminate on the basis of race, sex, age, religion, sexual orientation or physical challenges. I am a Child Development Specialist and Children's Mental Health Specialist. I teach Therapeutic Parenting Skills. I operate from a philosophical belief that the therapy process is most effective when the whole family participates. Duration of treatment will be negotiated as the therapy progresses. Good therapy is non-judgmental. I can invite you to look at the consequences of your choices. I have no right to judge anyone.

URGENT OR EMERGENCY SITUATIONS:

EMERGENCY…….. **911**
CARE CRISIS RESPONSE SERVICES (24 HOUR)…..... **1-800-584-3578**
CHILD PROTECTIVE SERVICES……. M-F 8:00AM TO 5:00PM **1-360-416-720** **A**fter hours **1-800-794-9402**
FOR HELP WITH A SELF TIME OUT CALL CONNIE AT… **360-542-6895** She will pick up if she can or return urgent calls as soon as she gets the message.

CLIENT SIGNATURE AND AGREEMENT:

I have received and read this sheet and understand it's content and intent. I understand the limits of confidentiality. I have received my copy of **Counseling or Hypnotherapy Clients, We Want You to Know** provided by the State of Washington for Counseling Clients. I understand that I am responsible to pay for each session in a timely manner. I understand that I may not get the results I want and that I can stop treatment at any time.

Connie Bonner-Britt, MA, LMHC:_____ Date:____-____-____

Client:_____ Date:____-____-____