

Client Information/Insurance Form Today's Date: _____

Full Name:

Street Address:

City: _____ State: _____ Zip Code:

Home Phone: _() _____ Work Phone:

() _____

Cell Phone: _() _____ Email:

Date of Birth: _____ Age _____ Gender: M _____ F

Marital Status _____ Employment Status

Emergency Contact:

Who referred you?

How will you be paying for your counseling?

Responsible party (if other than client)

Insurance Diagnosis (when required):

RELEASE TO BILL INSURANCE

I hereby authorize Qualls & Associates and Lakeshore Medical Billing to contact my employer and my insurance company in order to verify Insurance Benefits.

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to Qualls & Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my counselor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:

Relationship to Insured: _____ Date: _____

Information & Consent Form

1. **Dan Qualls** provides mental health/addiction/education/consulting services to adults and families through Qualls & Associates PLLC. My mission is to help individuals and families cope with the stressors of our day and to live more fully.

2. **SERVICE PROVIDERS:** Professional services are provided by a licensed and certified Masters-level therapist. Dan Qualls receives clinical supervision by a fully licensed Ph.D. where required by your insurance.

Therapist: Dan Qualls, MA, LPC, CAAC, CCS
6401004824

License #:

Supervision when required by insurance is by Dr. Patti Groessler, EdD – Muskegon,

MI

3. **CONFIDENTIALITY:** All information disclosed within sessions is confidential and may not be revealed to anyone outside the therapy session without your written permission except where disclosure is required by law and deemed to be in the best interests of the client or to avoid public peril (i.e. where there is reasonable suspicion of abuse of children or of violence to others; where the client is likely to harm him/herself unless protective measures are taken or pursuant to a lawfully issued subpoena). When minors (under age 18 years) are seen in therapy, the parent or guardian holds the legal privilege regarding release of information. Group therapy participants are expected to protect the privacy and confidentiality of other group members. Your therapist may discuss your case with her/his supervisor. The supervisor has the same ethical obligation to preserve your confidentiality.

3. **FEE(S) FOR SERVICES:**

• Initial diagnostic interview	\$120.00
• 50-minute individual session	\$100.00.
• 20-30 minute individual session	\$50.00
• Group Therapy (90 min)	\$50.00
• Driver's License	\$150.00 with report
• Drug Testing	\$55.00
• Court time	\$250.00 per hour

Fees are payable at our scheduled session. Charges will be assessed for additional services such as court reports or other third party reports, phone therapy sessions, etc.

IMPORTANT CONSIDERATIONS WHEN USING INSURANCE:

Loss of confidentiality - A psychiatric diagnosis will be in your medical history. If you elect to use insurance, we will submit bills to your insurance carrier and collect the benefit. You are expected to pay your deductible and copay at the time of your scheduled session.

5. **CANCELLATIONS:** We require notice of cancellations for scheduled appointments at least 24 hours in advance and will be charged 50% of full fee for sessions not canceled in advance.

Qualls & Associates – Dan Qualls MA, LPC, CAAC, CCS, CSAT

Grand Haven, MI 49417

6. **EMERGENCIES:** Voice mail is available for your nonurgent messages. In the event of an emergency, call your local crisis hot line, physician, or emergency care facility.

I HAVE READ THE ABOVE. I UNDERSTAND AND ACCEPT THE PROCEEDING CONDITIONS.

Client/Parent/Guardian's Signature

Date