CLEARVIEW
COUNSELING AND COACHING LLC
Facilitating Clarity from Within

I do hereby request to receive therapeutic services from Sharon Dunbar, MSW, LCSW for myself:

Name:_____ **DOB:**_____

Address: _____

Primary Phone:_____ **Other Phone:**_____ **Email:**_____

Services may include one or more of the following: Individual, Couple, Family, or Group Psychotherapy. I understand that while all reasonable effort will be made to accomplish the goals of the treatment plan as designed, Sharon T. Dunbar, MSW, LCSW does not guarantee the result of the treatment plan. It is further understood that all information given by the client or any family member to Sharon T. Dunbar, MSW, LCSW is confidential and will not be released without written permission. ***Exceptions: Suicidal or homicidal thoughts and or intent to harm self or others or knowledge of sexual or physical abuse of a child or elder. Also note, in rare instances, a court of law judge can require therapy records.***

Client Signature **Date**

Witness Signature **Date**

Insured Clients:

Clearview Counseling and Coaching LLC will not disclose any information to insurance companies. We will provide you with a receipt outlining date of service, diagnosis if applicable, provider's name, address, and phone number, and the charge. If you should decide to seek reimbursement from your insurance company, you may submit the receipt on your behalf.

Payment Policy:

Payment is due at the time of service. I agree to pay $250 per 1 hour. Sessions that exceed 1 hour are charged an additional $62.50 per 15-minute increments. A separate financial agreement will be made for Couples 2 Day Intensives.

Cancellation Policy:

If you are unable to keep your appointment, the office will request forty-eight (48) hours advance notice. This will permit enough time to provide service to another client. ***Appointments missed without 48 hours notice will be billed to the credit card on file at the rate of $250.00. A separate cancellation policy is included in the 2 Days Couples Intensive Agreement.***

I have read the above policies and understand and agree to the conditions as established and listed above.

Signature:_____ **Print Name:** _____

Witness:_____ **Print Name:** **Sharon T. Dunbar, LCSW**

Date: _____

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Consent and Disclosure of Protected Health Information

Use and Disclosure of Protected Health Information:
Under Florida State Law no Licensed Mental Health Professional may speak to anyone without your written consent. Exceptions to this are made in the case of reporting abuse or neglect, harm to self or others, or involuntary placement (Baker Act).

Notice of Privacy Practices:
You should review the notice of Privacy Practices for a more detailed and complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this document.

Requesting a Restriction on the use or Disclosure of your Information:
For purposes of continuity of care and only to benefit treatment Clearview Counseling & Coaching LLC may communicate with your other healthcare providers. This **will only be done with a separate consent** outlining the terms of what may be disclosed. You may request a restriction on the use of disclosure of your protected health information. Clearview Counseling & Coaching LLC may or may not agree to restrict the use or disclosure of your health information. If Clearview Counseling & Coaching LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreement upon restriction will be a violation of Federal Privacy Standards.

Revocation of Consent:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent was received will not be affected.

Reservation of Right to Change Privacy Practices:
Clearview Counseling & Coaching LLC reserves the right to modify the privacy practices outlined in the notice.

I_____have reviewed the Notice of Privacy Practices Information. I consent and give permission to Clearview Counseling & Coaching LLC to use and disclose my health information in accordance with it.

Signature Date

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Emergency Contact Information

This information will only be used in the case of an emergency such as an accident, medical emergency, or hospitalization. Signing this form gives Clearview Counseling & Coaching LLC the authority to contact the individuals on this form should the need arise as described in the above circumstances.

Your Name: _____

Phone: _____ Alternative Phone: _____

Address: _____

Primary Emergency Contact Name: _____

Relationship to you: _____

Phone: _____ **Alternative Phone:** _____

Secondary Emergency Contact Name: _____

Relationship to you: _____

Phone: _____ **Alternative Phone:** _____

Name of Primary Doctor: _____

Address: _____

Phone: _____

Any special medical information that emergency personnel should know; list all medical conditions, all medications, all past surgeries:

_____

_____

_____

_____

Signature: _____ **Date:** _____

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Clearview Counseling and Coaching LLC collects a means of payment from each client at the beginning of our relationship. We are happy to allow you to pay for sessions via cash or check, however, we still request a card to keep on file.

I authorize Clearview Counseling and Coaching LLC to keep my signature on file and to charge fees, or partial fees, to my credit card or debit card account for services provided to:

_____
Client Name

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services will normally be posted to my credit card account within 3 days of each service date. I understand that appointments not canceled in line with our cancellation policy will incur the normal charge.

I agree that if I have any problems or questions regarding charges to my account, I will contact Clearview Counseling and Coaching LLC for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Clearview Counseling and Coaching LLC and those attempts have failed.

_____
Cardholder Name

_____
Address including zip code

_____ _____ _____
Credit Card Number Expiration Date CVC Number

_____
Signature Date

1460 S. McCall Rd., Suite 3H
Englewood, FL 34223

(941) 473-2400
www.yourclearview.net

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