Abdo Counseling and Consulting, PLLC
1118 Sam Newell Road, Suite D2
Matthews, NC 28105
980-224-6612

- I will use my professional expertise, helping you with any problems you bring to therapy, or on issues that arise during sessions.
- Together we will establish your counseling/therapy goals and will clarify these from time to time.
- Please read the following carefully. Please discuss any questions you have before signing. You will receive a duplicate copy.

APPOINTMENTS:

- Your appointment time is being reserved for you and is scheduled to meet your counseling/therapy needs and appointment availability. Standard appointments are approximately 50 minutes long. Half sessions are approximately 25 minutes long.

TELEPHONE CALLS/AVAILABILITY:

- When I am not at the office I am available by telephone. Please call the office number 980-4042251, leave a message if I do not answer. I attempt to return calls as quickly as possible, within a 24hour period. If you are experiencing an emotional or medical crisis, go to the nearest hospital emergency room.

CANCELLATIONS:

- You will be charged $110 for a session you have failed to cancel within 24 **hours** of an appointment unless you cancel due to an unavoidable emergency. These fail-to-cancel visits are not billable to your insurance.

FEES AND INSURANCE:

- My fee $110 per visit. All fees and copayments are payable at the beginning of each session, cash or check (payable to Abdo Counseling and Consulting, PLLC.) If needed, arrangements can be made for a sliding scale fee or payment plan. My fee for collateral visits or consultations (e.g. court, school, medical team) will be discussed prior to providing these services. If you choose to pay privately instead of using your insurance, the fee is $ 90.00 for a 50minute session.

- Many insurance companies require a pre-authorization, many do not. Prior to our first meeting please ask your insurance company if you, as the member, need to acquire an authorization number or if I as provider need to fax a request for authorization.

- I am a provider for Medicare and UHC insurances. I will provide you with a ‘super-bill” for you to present to your insurance company for payment to you. In this instance payment of your session will be completed and a super-bill will be available for your submission.

- I am required to submit a diagnosis for insurance coverage for any client in treatment. If you would prefer that this information is kept private, a private pay agreement would be appropriate.

OFFICE COVERAGE:

- If I am ill or have a personal emergency, and I am unable to call to cancel your appointment, I will ask a colleague to contact you, if you request. I would not want you to come to your appointment and wait.

- Please indicate whether you would like to be called:

□	□	______
Yes	No	Please initial

- During vacations, my office is covered by one of my colleagues. The name of this therapist will be on my office message.

STATEMENT REGARDING CONFIDENTIALITY:

Information shared in this office remains confidential unless a specific release of information is signed by you ***with the following exceptions***:

- You express a planned intention of harming yourself or your emotional/mental state is observed by me to put you at risk for such an action.

- You express that you intend to do bodily harm to another person. (In that event, I am obligated by law to take reasonable precautions to ensure another's safety.)

- You share that you have in the past and/or present emotionally, physically or sexually abused a minor.

- You are a minor and you share that you are now being/or have been physically or sexually abused, or I determine that you are at significant risk.

- Your insurance company requests information relative to payment of your claim, or a request is made to collect unpaid fees, or any legal defense is required by your therapist relating to your care.

- I receive a signed order by a judge to testify in court, or to provide records.

- You complain of physical symptoms, or such symptoms progress while in therapy. You will be requested to obtain a physical examination to rule out medical basis for or increase in these symptoms, and allow communication between medical team and therapist.

- You are currently receiving Mental Health Services and/or are taking medication for a mental health condition, or if you need psychiatric care while receiving therapy, or if you have had previous Mental Health Services. You will be requested to permit me to speak with your prescribing physician, therapist or clinic.

- In the above areas I will take measures to ensure your safety. In all other areas, I may not reveal any information about you without your written permission. When insurance companies require me to submit clinical information about you to authorize additional sessions, I will try to complete insurance treatment forms with your input so you will know exactly what is being written about

you. Once the paperwork has left my office, I have no control over the confidentiality of the information.

STATEMENT REGARDING RELEASE OF INFORMATION:

- I understand that I may be asked to sign a Release of Information to permit JoAnn Abdo, LCSW, to speak with my physician(s), and/or provide pertinent medical records. I understand that I have the right to refuse to sign a Release of Information.

Please Initial __________

- I understand that, when applicable, I will be asked to sign a Release of Information to permit JoAnn Abdo, LCSW, to speak with current or previous therapist(s), and/or provide Mental Health Records. I understand that I have the right to refuse to sign a Release of Information.

Please Initial __________

- I understand that if I should I want to utilize my insurance, I will be asked to sign a Release of Information if I want JoAnn Abdo, LCSW to contact my insurance company for a referral or to obtain additional therapy sessions or to discuss payment of claims.

Please Initial __________

- I understand that if, at any time, JoAnn Abdo, LCSW determines that I need a different type of psychotherapy care, she will discuss my needs with me and transfer me to another provider.

Please Initial __________

- I give JoAnn Abdo, LCSW, permission to contact the person who referred me to her, as a courtesy.

Please Initial __________ ☐ Yes ☐ No

FINANCIAL AGREEMENT:

- I agree to pay _________________ per session.

- After insurance benefits are exhausted, I agree to pay ________________per session.

- If a check is returned due to insufficient funds, a reprocessing fee of $30.00 will be charged. After that incident, all payments will be requested in cash, postal money order or certified bank check.

I have read and understand the above statements on this page and the preceding pages and agree to the conditions stated.

Signed: _________________________________

Therapist: _____________________________ Dated: _______________________________________