TEAGUE & ASSOCIATES

Client Intake, Service Agreement, and Informed Consent

ALL INFORMATION MUST BE FILLED IN COMPLETELY.

Personal Information Date: ____________

Patient Full Name: __________________________ DOB: ______-______-______ Sex___

Address: _____________________________________ City: _______________________
State_____________________ Zip __________

Home Phone: (___) __________Cell Phone: (___) __________

Work Phone: (___) _______________ SSN______-______-______

Is it okay to call you at work? Yes/No (Circle one)

Do you work: Day/Night (Circle one) Marital Status: S M W D Separated (Circle one)

If we may contact you by **e-mail,** please list here:
____

Who may we thank for referring you? ___________ Are you a veteran? Yes/No

Emergency Contact: __________________________ Relationship: ___________________

Home Phone: (_____) ________________ Work Phone: (_____) ________________

Person Responsible for Account

Full Name: ___________________________________ Relationship: ___________________

Address: ___________________________ City: ______________ State: _____ Zip: _____

Home Phone: (____) _________ Work Phone: (____) ____________

SSN: ______-______-______

<u>Insurance Information-WE FILE PRIMARY INSURANCE FOR IN-NETWORK PROVIDERS ONLY</u>

Primary Insurance Company: ______________________________

Identification Number: _________________________

Group Number: ________________ Employer: ___________________________

Employer Address: ____

Insured Employee Full Name: ______________________________

Relationship: ___________________

DOB: ______-______-______ Insured SSN: ______-______-______

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Please Read Carefully

Professional services provided by Teague & Associates are provided to the patient, not the insurance carrier. Although every attempt will be made to collect from the insurance carrier, **this in no way releases the patient or guardian from responsibility of payment.** All insurance companies have a disclaimer stating that there is no guarantee of payment. In the event they do not pay, you will be responsible. By signing below, you are granting the following:

1. I authorize this office and/or its billing office to release any information necessary to expedite claim filing.
2. I authorize this office to release any information to another medical professional for the purpose of consultation or referral to facilitate the best possible care. A photocopy of this authorization shall be valid as the original. Information in your medical record is highly confidential and will only be released as stated herein.
3. I authorize payment from my insurance carrier directly to Teague & Associates. In the event I receive payment from my insurance carrier, I agree to immediately provide such payment to Teague & Associates. **If my insurance carrier does not pay for my session(s) and/or other time spent interactions and/or services, I agree to pay Teague & Associates their custom rate of $110 to $125. In event that my insurance company gives Teague & Associates incorrect information pertaining to copay, coinsurance, or deductible, I will not hold Teague & Associates liable for any overpayment towards copay, coinsurance or deductible but I can expect that the correct amount of payment will take place immediately from the time such overpayment is evident.**
4. Because therapists' time is limited, there may be a charge for telephone consultations. It will be prorated at $35 for each quarter hour.
5. I have received and signed for a NOTICE OF PRIVACY PRACTICES, as well as receiving a copy of TEAGUE & ASSOCIATES OFFICE AND PRACTICE POLICIES.
6. **I understand that I am responsible for ALL charges not paid by and/or not billed to my insurance company**. Such charges may be related to attorney fees, court costs, scheduling fees, documentation, case conceptualization, assessments, interpretations, phone calls, emails, insurance billing etc. Copies of records will be processed at the rate of $15.00 for the first five pages, $0.75 for pages 6-50, $0.50 for pages 51-250, and $0.25 for pages over 250. There may be a $15 retrieval fee if my file is over two years old.
7. I understand that if I have any outstanding balances Teague & Associates will send an invoice requesting payment within 15 days or a 1% monthly service charge will be added to the balance.
8. **I AGREE TO A CHARGE OF $70.00 FOR THE FIRST APPOINTMENT NOT CANCELLED 24 HOURS IN ADVANCE AND $90.00 FOR ANY SUBSEQUENT APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE; THIS FEE IS NOT BILLABLE TO MY INSURANCE COMPANY. I AM RESPONSIBLE FOR KEEPING TRACK OF MY APPOINTMENTS.**
9. **I AGREE TO A $1500.00 RETAINER FEE IF MY THERAPIST IS SUBPEANAED OR INVOLVED IN COURT PROCEEDINGS. Therapists' time is limited, so he or she will not participate in court hearings. If a therapist must attend court for any reason, I agree to pay the retainer fee and any additional related fees.**
10. **I understand if I need an emergency appointment, I am responsible for paying a $50.00 charge IN ADDITION to my copayment or regular office payment if my appointment is made in less than 24 hours unless my therapist already has an opening in his or her schedule.**

Does (Teague, Teague & Associates) have permission to call and leave a message to remind you of your appointment? ___Yes___No. If yes, what number? ___________________Initial: _____

BY SIGNING BELOW, I AGREE THAT I HAVE CAREFULLY READ ALL THE TERMS ABOVE AND HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS I HAD, AND I FULLY UNDERSTAND ALL AREAS COVERED. I GIVE MY INFORMED CONSENT TO PARTICIPATE IN THIS TREATMENT PROCESS.

_____________________________ __________ _____________________________ _______

Signature of Patient/Guardian Date Witness Date

TEAGUE & ASSOCIATES
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PSYCH-SOCIAL INFORMATION

Date_______________ Patient Name___________________________________ Age______________

Reason for Visit:

Current Stressors/Problems:

PAST THERAPY/PSYCHIATRIC TREATMENT

Dates	Place	Therapist Name
______________________	_______________________	_______________________
______________________	_______________________	_______________________
______________________	_______________________	_______________________

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed.

Number of marriages (including current marriage) _______________________________

Length of each marriage (years) 1st_____ 2nd_____ 3rd_____ 4th_____ 5th_____

Number of children__________ Ages_____; _____; _____; _____; _____; _____; _____

Names of persons in household	Relation	Age
_____________________________	____________________	________________
_____________________________	____________________	________________
_____________________________	____________________	________________
_____________________________	____________________	________________

Last grade completed/Level of education_______________________________________

Current job________________________ How long? ___________________________

Number of jobs held in the past five (5) years___________________________________

Do you have any current or past legal proceedings? _____Yes _____ No

If yes, please explain

____

____

TEAGUE & ASSOCIATES

Client Intake, Service Agreement, and Informed Consent

Name_____________________________________ Date___________________________

MEDICAL INFORMATION

Some symptoms which may seem to be psychological in nature have a physical cause. It is important to obtain medical history, recent symptoms, past major illnesses and surgeries, current medications, lifestyle health habits, and family history of medical and psychological problems. This information will be kept confidential.

Family Physician Name______________________________ Date of Last Visit________________

Physician's Address_________________________________ Telephone Number______________

Please check any of the following symptoms experienced within the last three (3) months:

_____ Allergies
_____ Abdominal pain/cramps
_____ Back pain
_____ Blackouts/amnesia
_____ Blood pressure problems
_____ Blurred vision
_____ Change in sex drive
_____ Change in speech (slurred/stuttering)
_____ Chest pain or discomfort
_____Concentration problems
_____ Constipation
_____ Diarrhea
_____ Difficulty breathing
_____ Difficulty sleeping
_____ Difficulty swallowing
_____ Dizziness/light-headedness
_____ Fainting
_____ Frequent cough
_____ Headaches
_____ Impotence
_____ Increased need for sleep
_____ Irritability
_____ Memory problems
_____ Nausea or vomiting
____ Night sweats
_____ Tremors
_____ Palpitations/pounding heartbeat
_____ Racing heart rate
_____ Restlessness
_____ Ringing or roaring in ear
_____ Weight gain with(out) increase in appetite
_____ Weight loss with decrease in appetite
_____ Weight loss without decrease in appetite
_____ Other ________________________________

Please list any significant illnesses, injuries, or surgeries and dates: _________________________________

Please list all medications taken in the last six (6) months (including over-the-counter medications):
____

Do you use tobacco? _____ Yes _____ No How much per day? ________________________

Do you smoke marijuana? _____ Yes _____ No How much per day? ______________________

Do you drink alcohol (beer, wine, liquor)? _____Yes _____No How much? _______________________

Do you drink caffeinated drinks (coffee, soft drinks, tea)? ____Yes ___No How much? _________

Have you or any blood relative suffered from:

Alcohol or drug problem	_____Self	_______________ Which family member?
Depression	_____ Self	_______________ Which family member?
Anxiety or "nerve" problem	_____ Self	_______________ Which family member?
Schizophrenia	_____ Self	_______________ Which family member?
Attention Deficit Disorder	_____ Self	_______________ Which family member?

TEAGUE & ASSOCIATES

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Religious and Spiritual Questions

Name: _________________________ Date: ____________

1. How much is religion and/or God a source of strength and comfort to you?

   None 1 2 3 4 5 Great Deal

2. Do you pray? Yes ____ No ____

   How often do you pray? Never Monthly Weekly Daily

3. Does your faith play an important role in your life? Yes ____ No ___

4. Do you attend regular religious services?

   Never Monthly Weekly More than once a week

5. Does you religious faith or spirituality influence how you take care of yourself and your health?

   Yes ____ No ____

Notice of Privacy Practices

TEAGUE & ASSOCIATES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLESED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS INFORMATION CAREFULLY

EFFECTIVE DATE: APRIL 14, 2017

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

We are required by a new federal law entitled Health Insurance Portability and Accountability Act (HIPAA) to safeguard your Protected Health Information (PHI). PHI is individually identifiable information about your past, present, or future health condition, the provision of health care to you, or payment for healthcare. We are required to give you notice of our privacy practices for the information that we collect and keep about you.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that health information about you is personal, and we are committed to protecting this information. This Privacy Notice applies to all your health information, including 1.) records relating to your care at this practice and/or 2.) health care records received by us from another source.

We are required by law to 1.) keep your PHI confidential; 2.) give you this Privacy Notice; and 3.) follow the terms of this Privacy Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND OPERATIONS

The following categories describe different ways we may use and disclose your PHI:

For Treatment: We may use or disclose your PHI to other doctors who are involved in taking care of you. However, you will be asked to sign a release form before this information is released.

For Payment: We may use or disclose you PHI to obtain payment for health services that you receive. For example, we may need to tell your health insurance about a treatment you need to obtain prior approval or to determine whether your insurance will pay for treatment.

Appointment Reminders: We may use your PHI to contact you as a reminder that you have an appointment for therapy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR PERMISSION

The law provides that we may use or disclose your PHI form our records (even after your death) without your permission in the following circumstances:

As Required by Law: We will disclose medical information about you when required to do so by law, investigate reports of abuse or neglect, and report the incident to the appropriate law enforcement agency.

Health Oversight Activities: We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the state and federal government to monitor the health care delivery system in Tennessee.

Public Health Risks: We may disclose PHI about your public health activities. These activities may include the reporting of births and deaths and the tracking, prevention, or control of certain diseases, injuries, and disabilities.

Research: In certain circumstances, and under supervision of an institutional review board, we may disclose PHI to assist medical research.

To Avert a Serious Threat to Health or Safety: We may use or disclose your PHI if necessary to prevent a serious threat to you or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

For Specific Government Functions: We may disclose PHI to law enforcement, to government benefit programs relation to eligibility and enrollment, and for the interest of national security.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to Amend: If you feel there is a mistake or missing information in our record of your PHI, you may ask us to correct or add to the record. Your request must be made in writing, and you must provide a reason that supports your request. We may deny your request under certain circumstances. Any denial will state the reason for denial and explain your rights to have the request and denial, along with any statement in response you provide, appended to your PHI.

Right to Know What Health Information We Have Released: You have the right to ask for a list of disclosures made of your PHI made on or after April 14, 2003, for purposes other than those listed in the Privacy Notice. You must request this list in writing and state the period the list should cover for a period no longer than six (6) years. The first list you request within a twelve (12) month period will be free.

Right to Request Restrictions: You have the right to ask us to limit how your PHI is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom the limits apply. For example, you could ask that we not disclose to your spouse information about a blood test you received. We are not required to agree to your request. If we agree, however, we will comply with your request unless the information is needed to provide you with emergency treatment or the information can be disclosed without your authorization.

Right to Confidential Communications: You have the right to ask that we communicate with you in a certain way or at a certain place. For example, you may ask us to send information to your work address, instead of your home address. You must make your request in writing. You will not have to explain the reason for your request. We will honor all reasonable requests.

Right to Authorized Release Information: Other releases of your PHI can be made only if you request it and you can change your authorization at any time. This involves your signing an exchange of information form.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. We reserve the right to change our privacy practices and this notice at any time.

HOW TO GET MORE INFORMATION OR COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice, please contact the PRIVACY OFFICER listed below. If you believe we have violated your privacy rights, you may file a written complaint with the agency listed below. You will not be affected by filing a complaint.

TN Department of Health's Privacy Officer 877-280-0054

Bureau of Health Informatics Fax: 615-532-1886

Sixth Floor, Cordell Hull Building

425 Fifth Avenue North **http://www2.state.tn.us/health/HIPAA/**

Nashville, TN 37247-0460

DOCUMENTATION OF NOTIFICATION

I have been given the NOTICE OF PRIVACY PRACTICES, which describes the Privacy Practices of Teague & Associates, and I have had the chance to read it and to ask questions.

_______________________________________ ___________________

Client Signature **Date**

TEAGUE & ASSOCIATES
Client Intake, Service Agreement, and Informed Consent

TEAGUE & ASSOCIATES
Mental Health & Life Skills Professionals
805 South Church Street, Ste. 17
Murfreesboro, TN. 37130
Phone: 615-809-5995 Fax: 615-777-3535
www.teagueandassociates.com

Credit/Debit Card Authorization

I ______________________________ give Teague & Associates authorization to charge $70 FOR THE FIRST APPOINTMENT NOT CANCELLED 24 HOURS IN ADVANCE, $90 FOR ANY SUBSEQUENT APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE, $90 FOR TWO OR MORE CONSECUTIVE MISSED SESSIONS, $90 FOR MISSING MORE THAN TWO SESSION IN ANY 30 DAY PERIOD and $90 FOR MISSING ANY SESSION IF YOUR SESSIONS ARE EVERY OTHER WEEK or ONCE A MONTH to the credit card provided below.

Teague & Associates is not otherwise authorized to charge any other fees outside of my presence without my permission. I agree to update my credit card information immediately upon the expiration of the credit card given in this authorization.

Type of Card: __ Visa __Master __Discover
Credit Card#: _________________________________
Expiration Date: _______________________________
CV# (3-digits on back): ____________
Zip Code: _____________
Name as it appears on front of credit card: ______________________________

Print: ____________________________ Signature: __________________________
Client or Guardian of Client Client or Guardian of Client

Signature: ________________________
Witness

TEAGUE & ASSOCIATES

Client Intake, Service Agreement, and Informed Consent

Corey M. Teague, PhD *Emily S. Teague, LCSW*

Welcome to our practice. **Please read it carefully** and jot down any questions you might have. Teague & Associates in this informed consent refers to *Corey M. Teague PhD* and/or *Emily S. Teague, LCSW.*

Your signature on this document indicates that you have read the information in this document **[Teague & Associates Informed Consent (document #007)]** and agree to abide by its terms during and after our professional relationship. You agree that you are not a client of Teague & Associates (i.e., Corey M. Teague, PhD, or Emily S. Teague, LCSW) until you have signed this document.

PSYCHOTHERAPY SERVICES

There are many different methods I may use to deal with the problems that you hope to address. It is my discretion as it relates to which method(s) is used during our sessions. You agree not to hold me liable in any legal or non-legal manner if you disagree with my decision(s) related to methods used while dealing with the problems you hope to address.

Psychotherapy calls for a very active effort on your part. For the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. But there are no guarantees of what you will experience.

MEETINGS

I normally conduct an **evaluation that will last from 2 to 3 sessions**. I will usually schedule one **45–60-minute session per week** at a time we agree on, although some sessions may be longer, shorter and more frequent. We normally do not offer every other week sessions. Recording and videoing sessions are not regular practices, but meetings may be recorded and/or videoed at my discretion. Once an appointment hour is scheduled, you will be expected to pay a fee unless you provide 24 hours advance notice of cancellation.

Cancellations without Notice

If you do not cancel with 24-hour notice, there is a **$70 fee for the first occurrence and $90 thereafter**. This fee will need to be paid prior to resuming your counseling sessions. Also, if you happen to miss your session, be sure to reschedule as soon as possible. **Failure to pay the fee and/or reschedule within a week of the missed session may result in the loss of your session time slot.** In the event of the loss of a time slot, every effort will be made to reschedule you at a different time slot as soon as possible. **Failure to maintain a consistent session schedule may result in you losing your session slot.**

Cancellation with Notice

If you do cancel with 24-hour notice, there is no fee. However, if your sessions are every other week or once a month, then **you agree to pay $90 for cancelling or missing your session**. **Also, if you cancel for two (2) or more consecutive weeks, you agree to pay a $90 fee for each consecutive week. Also, if you cancel two (2) sessions within one (1) thirty-day period, you agree to pay a $90 fee for the second cancelled session within those 30 days.** This fee will need to be paid prior to resuming your counseling sessions. Even if you happen to cancel your session with notice, be sure to reschedule as soon as possible. **Failure to pay the fee and/or reschedule within a week of the missed session may result in the loss of your session time slot.** In the event of the loss of a time slot, every effort will be made to reschedule you at a different time slot as soon as possible. **Failure to maintain a consistent session schedule may result in you losing your session slot.**

SESSION AND PROFESSIONAL FEES

Our session fee for self-pay clients is $110 - $150. In addition to weekly appointments, I charge specific and different amounts for other professional services you may need. **Our follow up 30-minute session fee for self-pay clients is $70.**

BILLING, PAYMENTS, AND INSURANCE

See Payment Options Addendum

CONTACTING ME

I am **often not immediately available by telephone**. While I am usually in my office during my office hours, **I will more than likely not answer the phone when I am with a client**. When I am unavailable, my telephone is answered by voice mail that I monitor frequently, or by my colleague who knows where to reach me. If you are unable to reach me and feel that you can't wait for me to return your call, **in event of an emergency, contact your family physician or the nearest emergency room** and ask for the psychologist or psychiatrist on call.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. **You are entitled to receive a copy of your records**, or I can prepare a summary for you instead (recommended). Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, **I recommend that you review them in my presence so that we can discuss the contents**. Clients will be charged an appropriate fee for any professional time spent responding to information requests.

MINORS

If you are under eighteen years of age, **please be aware that the law may provide your parents the right to examine your treatment records**. **It is my policy to request an agreement from parents that they agree to give up access to your records**. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. Sessions may be recorded at my discretion.

CONFIDENTIALITY

In general, **law protects the privacy of all communications between a client and a psychotherapist**, and I can only release information about our work to others with your written permission. But there are a few exceptions.

CONFIDENTIALITY EXCEPTIONS

(1) In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. **(2)** There are some situations in which I am legally obligated to take action to protect others from harm, even if I must reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. **(3)** If I believe that a client is threatening serious bodily harm to self or another, I am required to take protective actions. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. **(4)** I may occasionally find it helpful to consult other professionals about a case.

CONFLICT OF INTEREST

We will be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. We will inform you when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes your interests primary and protects your interests to the greatest extent possible. In some cases, protecting your interests may require termination of the professional relationship with a proper referral for you. You agree that it is at Teague & Associates' total discretion to decide what a conflict of interest is, and you agree not to hold Teague & Associates liable in any legal or non-legal manner if you disagree with Teague & Associates' decision to make a referral for you based on Teague & Associates decision that a conflict of interest exist.

COMPETENCE

Teague & Associates will practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, Teague & Associates will gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

Teague & Associates will practice in specialty areas new to them only after appropriate education, training, and supervised experience. When generally recognized standards do not exist with respect to an emerging area of practice, Teague & Associates will exercise careful judgment and take responsible steps to ensure the competence of Teague &Associates' work and to protect clients from harm. While developing skills in new specialty areas, Teague & Associates will take steps to ensure the competence of their work and protect others from possible harm.

If Teague &Associates lack the competence to be of professional assistance to clients, they will avoid entering or continuing the counseling relationship you. Teague & Associates are knowledgeable about culturally and clinically appropriate referral resources and will suggest these alternatives. If you decline the suggested referrals, Teague & Associates will still discontinue any relationship you. You agree that it is at Teague & Associates' total discretion to decide any professional competence conclusions and you agree not to hold Teague & Associates liable in any legal or non-legal manner if you disagree with Teague & Associates' decision to make a referral for you based on Teague & Associates' decision that Teague & Associates' lack of competence exist.

Your signature on this document indicates that you have read the information in this document **[Teague & Associates Informed Consent (document #007)]** and agree to abide by its terms during and after our professional relationship. You agree that you are not a client of Teague and Associates (i.e., Corey M. Teague, PhD, or Emily S. Teague, LCSW) until you and Corey M. Teague, PhD or Emily S. Teague, LCSW have signed this document.

________________________________ ________________________________

Print Name (Client) Print Name (Guardian of Client)

________________________________ ____________________

Sign Name (Client or Guardian of Client) Date

________________________________ ____________________

Emily S. Teague, LCSW Date

________________________________ ____________________

Corey M. Teague, PhD Date

TEAGUE & ASSOCIATES

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Payment Options Addendum

These are the payment options that are available. Please check the box that indicates the payment option that you agree to pay.

Affordable Self-Pay Rates:

- ☐ Option 1: 50 – 60 minute sessions: $120.00 - $150.00
- ☐ Option 2: 30 minute follow up sessions: $70.00

***Insurance Rates:**

- ☐ Emily S. Teague, LCSW: $110.00 minus what insurance pays after co-pay, coinsurance, or deductible.
- ☐ C.M. Teague, PhD, LPC, MHSP: $125.00 minus what insurance pays after co-pay, coinsurance, or deductible.

You will be expected to pay for each session at the time it is held. This fee includes the copay, coinsurance, or partial deductible payment, not greater than or less than $110 or $125. Once we have all the information about your insurance coverage, we will discuss what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. **Teague & Associates will not be financially responsible for any miscommunication or misunderstanding of fees, insurance reimbursement, copay, or coinsurance or deductible. Teague & Associates will give no refunds for any reason but will negotiate a partial credit arrangement to be deducted from future session rates.**

*Insurance option examples:
1. Fee ($125) – Insurance Claim Payment ($52) = Your Payment ($73)

2. Fee ($110) – Insurance Claim Payment ($52) = Your Payment ($58)

Please note that these are examples of the insurance option and may not reflect what you may pay. The fee billed to the insurance company is $150.00, which is discounted by the insurance company. A portion of the $110.00 or $125.00 is for non-billable or non-covered activities related to the psychotherapy process.

Your signature on this document indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_______________________________   ____________
Client – Print Name   Date

____
Client – Sign Name