Stephanie Lane M.A., LPC, ATR-BC
2000 E. 15th Street 450c
Edmond, Oklahoma 73013
(405)503-2791

SERVICES AND FEES

Evaluation and assessment- the first three-five sessions will be a time of assessment and evaluation. During this time of information gathering and evaluation you and your therapist will plan your treatment goals and appropriate type of therapy suggested to reach your goals.

Therapy Fees-	**Intake/Assessment**	**$140 -**	**60 minutes**
	Individuals -	**$120 -**	**60 minutes**
	Couples & Family	**$140 -**	**60 minutes**
	Infertility Counseling & Consultation	**$150 -**	**60 minutes or service**

Sessions:

The first 60 minutes we will spend gathering information, working on finding solutions to living and maintaining better quality of life. Sessions are 60 minutes for both traditional therapy and art therapy.

Payment, Insurance, and Self-Pay

Payment is expected upon time of services. Insurance is accepted but not required for treatment. If utilizing insurance, co-pays and deductibles are expected upon time of service. If you are utilizing insurance benefits you must sign the release provided to you in this form in order to bill your insurance carrier. I accept cash, credit cards, and checks.

1. Your therapist may seek consultation with professional colleagues about our work without seeking permission. However, your confidentiality will be protected by keeping your identity unknown.

TERMINATION OF TREATMENT

Treatment may be terminated if payment is not timely, if psychological prescriptions are not filled (such as seeking a psychiatric consultation, maintaining the boundaries which make psychotherapy possible. If a problem

emerges that is not within the therapist's realm of expertise I will assist in you in finding a therapist better suited to your needs.

Please be aware that there are certain risks involved in psychotherapy. Both traditional therapy and art therapy evoke unconscious thoughts and feelings that can be unpleasant. Past memories and emotions may be triggered that create emotional discomfort, irritability, frustration, and depression. Often this is the power of therapeutic work taken form that leads to spiritual growth, transformation in relationships, and overall improvement in quality of life. However, not everyone benefits from therapy and there are no guarantees.

EMERGENCY SERVICES

If there is an emergency that cannot wait until our next session you may call (405) 503-2791. Your call will be returned as soon as possible. In the event I am unable to return your call in a crisis, please call 9-1-1, or go to the nearest emergency room. You may also call Oklahoma County Crisis Intervention Center at (405) 271-5050 or contact Heartline (405) 848-2273.

Please state or list your main goal or goals you are seeking therapy for:

_____

_____

Thank you and
I look forward to working with you

_____ _____
Signature Date

LANE
COUNSELING & INFERTILITY

Stephanie Lane, M.A., LPC, ATR-BC

Client Information:

Name:_____Age:_____Date of Birth:_____

Sex: M___F____ SSN:_____ Marital Status:_____

Address:_____

City_____State_____Zip:_____

Home Telephone:_____Work:_____ Cell:_____

Your Occupation:_____Who Referred You? _____

May I contact the person who referred you to say "thank you"? If so, please sign giving your permission:_____

Emergency contact: (This person will only be contacted in the event of medical emergency): _____ Telephone:_____

Primary Insurance:_____

Policy Holder_____

Policy Holder DOB_____/_____/_____

Policy Holder Employer:_____

Your relationship to policy holder:_____Policy Holder SSN:_____

Insurance contact#_____ Policy Holder Phone #_____

Policy Holder address (if different from above address)

_____

LANE
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Please read and sign the following authorizations and assignments:

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The client is responsible for all fees, regardless of insurance coverage. Payment is expected upon time of service.

Client Signature:_____Date:_____

Please sign the following consent release authorizing me to bill your insurance

Consent for release of information: Stephanie Lane-Hicks may disclose any part of the client's record to third party payers such as commercial carriers for the purpose for the patient's bill. This consent does not preclude the patient's right to privacy. The therapy record will remain a confidential document requiring express written consent of the patient for all other disclosures.

Client Signature: _____Date:_____

Authorization to pay insurance benefits: I hereby authorize payment directly to Stephanie Lane-Hicks, benefits otherwise payable to me but not to exceed the regular charges for this period. I understand that I am financially responsible to the Center for charges not covered by this authorization.

Client Signature:_____Date:_____

Family History: Alcohol, Substance abuse or Psychiatric Illnesses:

Have you or anyone in your family had a history of drug and alcohol abuse?

_____

_____

_____

Have you or anyone in your family been diagnosed with any psychiatric disorders such as Bipolar I Disorder, Bipolar II Disorder, Schizophrenia, and Schizoaffective Disorder?

_____

_____

If yes, indicate relation to family member_____

If you drink alcohol, wine, beer, liquor how much do you consume in a week?_____

Do you drink or use drugs recreationally? _____If yes, how often?_____

Do you currently have a psychiatrist? _____Do you have a Primary Care Physician?_____

List any psychotropic medications: Please list any additional medications and include how often &
dosage_____

_____

_____

_____

How many hours of sleep do you normally require to feel rested?_____

How many hours of sleep do you currently get?_____

LANE
COUNSELING & INFERTILITY

Please read and sign the following procedures for 24 hour cancelation policy, hippa and practice information.

Client Information, Consent to Receive Services and Hippa Compliance

I agree to pay the current rate of $90 for no-show appointments and $50 for appointments that are not canceled by phone at **least 24 hours in advance** since that session was exclusively reserved for me and cannot be used for another client without advance notice. I understand that such charges are not covered by insurance or other third party payers; therefore, I will be personally liable for charge.

Client Signature_____Date_____

_

Please read and check the circles indicating you have read and understand policies and Hippa regualation.

- Regular therapy sessions are 60 minutes
- I understand that by entering treatment, I must conduct myself in sucha a way as to protect myself and others from exposure to, or transmission of any infections such as STD's or communicable diseases.
- All information which is shared with me will be kept strictly confidential and cannot be released under ordinary circumstances, without your

permission. The following exceptions supersede confidentiality and include duty to warn.

- A “duty to warn” ethic requires that confidentiality be broken when it clearly appears that a danger exists to the client and/or others.

- Child or elderly abuse/neglect

- Legal proceedings, court, , and or other legal agents if aware of your contact with me may subpoena records or have me give testimony during a court hearing. In such an event the court would waive your right to confidentiality.

- Insurance companies have the right to request records for which a claim for payment is made.

- I understand that Stephanie Lane is licensed to practice as a Board Certified and Registered Art Therapist by the Art Therapy Credentials Board and as a Licensed Professional Counselor by the Oklahoma State Department of Health and that her registration number for art therapy is clearly displayed in office as well as LPC license. I understand if I have questions regarding the practice of Stephanie Lane ATR-BC, LPC, I may contact the ATCB and the Oklahoma State Department of Health’s LPC office (with or without giving my name) by calling 405-271-6030, or by writing to Oklahoma State Department of Health, LPC 1000, NE 10th St. Oklahoma City, OK 73117-1299.

- Your signature below assigns all mental health benefits by our insurer, including government sponsored programs, private insurance, and any other health plan, to Stephanie Lane, ATR-BC, LPC. This assignment will remain in effect until resolved in writing. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Stephanie Lane, ATR-BC, LPC to release all information necessary to secure payment.

- Email Policy: You are welcome to email Stephanie Lane at Stephanie@LPC.coxinet.net with the understanding that (1) this e-mail is not a secure form of communication and although confidentiality will not be deliberately breached, it is not guaranteed; (2) Most emails will not be

answered and are considered therapy material to be discussed at your next session; (3) billing matters, appointment changes/cancellations and requests for call backs can only be accepted by phoning my cell phone of which you have been provided with; and (4) e-mail is not to be used for emergency situations or threats to harm self or others.

- Social media: I post blogs and professional articles on some social media forums for professional and educational purposes. Social media and electronic communication is for professional use only and not for personal communication as this crosses boundaries and can compromise the therapeutic relationship.

Payment for all visits is expected at the time of visit. If you have insurance and I can determine if you have met your deductible and what your co-pay is prior t the intake session, you may pay your co-payment at the Intake. Otherwise, the first session will need to be paid in full. You will be refunded at a later date or credited for future sessions if your deductible has been met prior to the first intake session. Your signature indicates that you (1) have read and agreed to the Client information and Consent to receive treatment, (2) will accept ultimate responsibility to pay for all services rendered, (3) have read the contact information for the LPC office, and (4) have read and agree to the email policy.

_____

Client or authorized person's printed name

_____

Client or authorized person's signature

_____

Staff Witness

LANE
COUNSELING & INFERTILITY

Credit Card On File
Billing Authorization Form

Patient's Full Name_____

Card Holders Refation to Patient:_____

Card Holder's Address:_____
Street

_____
City State Zip Code

Please check one:

☐ Visa ☐ MasterCard ☐ Discover

Name as it appears on Card:_____

Credit Card #:_____

Expiration Date:_____

Zip Code:_____

CCV# (3 digit number on back of card):_____

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I understand and agree to the terms set forth by this agreement as well as those agreements contained in the completed patient intake packet. I agree to pay and specifically

Stephanie Lane-Hicks LPC/ATR-BC to charge credit card for the counseling services provided. I understand I will receive an invoice upon request. I further agree that in the event this credit card becomes invalid, I will provide Stephanie Lane, LPC/ATR-BC with valid new card to be charged for the payment of any outstanding charges owed to Stephanie
Lane, LPC, ATR-BC. Theses authorized payments include no show and cancelation fees set in the client intake packet that have been signed and understood as agreed upon.

Signature:_____

Name (Please Print):_____

Date:_____

2000 E. 15th St. 450c, Edmond, OK 73013 | CELL PHONE: 405.503.2791 | FAX: 405.513.8471 | E-MAIL: Stephanie@LPC.coxinet.net

I accept cash, check, credit card payments and payments through certain apps that are private and meet hippa requirements. If you prefer to write a check I will accept with the understanding that if check is returned for insufficient funds you will be charged the same bank fee that I am charged with for insufficient funds. The fee for returned items is $20.00 and you will be charged this in addition to the amount due for service.

I understand I will be charged $20.00 for returned checks by signing below:

Client Signature_____ Date_____