Family Counseling Center
PO Box 929
Ruston, LA 71273-0929
318-255-5753

FCC Policies:

We ask:

- Give 24 hours' notice of cancellations
- Due to the high demand for appointments, two consecutive or more "no shows" may result in the loss of regularly scheduled appointment time
- A fee of $25 is charged per "no show" and is unbillable on insurance
- Understand that phone calls over ten minutes are considered therapy and client will be billed accordingly

By signing, I am indicating that I understand and agree to the above information.

_____
Name of Client

_____ _____
Signature of Client Date

Louisiana United Methodist Children and Family Services, Inc.
Family Counseling Center
902 Deville Lane
Ruston, Louisiana 71270

Liability Release Agreement

This agreement is made and entered into by and between the household and all of its members identified as, _____ (your name), represented herein by _____ (your name), head of the household

AND Louisiana United Methodist Children and Family Services, Inc.

I,_____, do hereby agree to hold harmless and release the Officers, Directors, and Staff of the Louisiana United Methodist Children and Family Services, Inc. of any liability for injury or damage, real or perceived, to myself or persons from the household I represent which may arise while receiving counseling services and any other service that may be rendered to our household prior to, during, or after the duration and completion of our service agreement entered into with the Louisiana United Methodist Children and Family Services, Inc.

I,_____, do assume all responsibilities for decisions, choices, and behaviors that I may individually make and for those made by any member of my household. I understand that my therapist is assisting me to think through and come to resolution of issues within my own sphere of life. My therapist is a facilitator and consultant and not the initiator, nor determination, nor determinator of my thoughts or actions for me individually or for members of my household.

I hereby declare to relieve _____, my assigned therapist, and any other therapist that may be assigned to assist me in the future. The Board of Directors, its Officers and Staff of the Louisiana United Methodist Children and Family Services, Inc. and its Family Counseling Center of any and all liabilities for consequences of my decisions and actions and for those of all the members of my household.

AND WITNESS WHEREFORE, of this agreement is signed and entered into on the date below indicated as witnessed.

_____

Client Date

_____

Witness Date

Family Counseling Center

902 Deville Lane Ruston, Louisiana 71270

Payment Agreement for Clients

I, _____ (Client), enter into this agreement with Family

Counseling Center on _____for the purpose
(Month, Day, Year)

of establishing a therapy payment plan. I understand the fee for therapy is $120.00

per fifty-minute session. This fee is to be paid at the beginning of each session. If I

qualify for the fee reduction, I agree to pay the following amount_____.

The Family Counseling Center will assist with filing insurance claims; however, each client will be responsible for making payment at the time of each office visit unless prior arrangements have been made between the Family Counseling Center and the insurance company.

I am aware that twenty-four hours notice is required for cancellation of all appointments. I understand that I will be charged the standard session fee for the session missed if not canceled twenty-four hours prior to appointment time except in cases of emergency. I am aware that charges for missed appointments may not be claimed on insurance coverage. I have read this agreement and agree to be bound by it.

Individuals who do not have insurance coverage and cannot afford the full rates may apply for a fee reduction. In order to apply for a fee reduction, I understand that I must complete an income worksheet and attach copies of my most recent tax return and three recent pay stubs.

_____ _____

Print name *Signature*

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OFF CAMPUS POLICY

In an effort to meet the increasing requests for our therapists to provide services off campus, FCC has developed the following policy:

1. No travel beyond 20 miles.
2. Off-site services fee will be the same as your regular session fee of $_____/hour. Fee is due before off-site visit can be made.
3. In order for therapists to observe children/clients in classroom settings, parent or guardian must sign a release of information form giving therapist permission to speak with teacher/principal about client and observe client in school setting.
4. Parent/guardian will arrange time and date of off campus appointment.
5. Be signing below I am acknowledging that I understand and will abide by the FCC Off Campus policy.

_____
Signature of Parent/Guardian Date

On behalf of _____(Child/Client)

Circle therapist below:

Pam Cannon / Robert Flowers / Chad Frederick / Ginny Hixon / Sharon Kilcoyne / Amy McKaskle / Marsha Watkins / Jessica Williams

Intern:_____

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TO ALL CLIENTS OF FAMILY COUNSELING CENTER:

FCC therapists believe that it is in the best interest of our child clients that we remain neutral during custody battles. We also agree that therapists who participate in custody battles put at risk the therapeutic relationship between therapist and child client. Research clearly shows that a positive relationship between client and therapist is the most important predictor of positive outcomes in therapy, regardless of the model or techniques used. Therapy should be a safe, battle free zone for our child clients and we strive to protect and maintain this relationship at all costs. We respectfully ask parents to honor their child's ability to heal by allowing therapists to remain 'on the child's side' throughout the duration of the therapeutic process.

Regarding requests or subpoenas for our therapists to testify in court regarding custody of child clients, please be advised that:

1. Therapists involved in counseling services are not conducting custody evaluations and therefore are not qualified to provide an opinion as to child/client placement for the court.
2. If required through subpoena or court order to testify, our therapists' testimony will consistently reflect that it is not our professional role to express an opinion regarding the placement of a child.
3. If required through subpoena or court order to testify, client will be charged $300 per hour. Billing time begins when therapist leaves the Family Counseling Center and ends when therapist returns.
4. A deposit in the amount of $600 for two hours will be required twenty-four hours prior to the assigned court date.
5. Documents required by the court or requested by client (such as summaries of therapy) that are expressly for the purpose of court litigation will cost $120 per hour for preparation. Payment will be the sole responsibility of the client requesting such document.

By signing below, I acknowledge that I have read and understand the above information.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

FAMILY COUNSELING CENTER
Louisiana United Methodist Children and Family Services

CONSENT TO USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION

As part of your treatment, Family Counseling Center will be collecting information for you in your mental health record. This information is referred to as Protected Health Information (PHI). By signing this consent form, you are allowing us to use and disclose your PHI for treatment, payment and health care operations as noted in our Notice of Privacy Practices, or as allowed/required by law. If you choose not to sign this form, Family Counseling Center will be unable to treat you. The Notice of Privacy Practices explains your rights and how we can share your information in more detail.

If any information in our Notice of Privacy Practices changes, you can request a copy of the most current notice by contacting us 318-255-5753, or you can refer to the copy posted in our office.

You have the right to request, in writing, a restriction or limitation on the PHI that we use or disclose about you for treatment, payment or health care operation. However, we are not required to agree to these limitations. If we do agree to your request, we will comply with this request unless complying with the request is against the law or unless the information is necessary for treating you in the event of an emergency.

You have the right to revoke your consent after signing this form by submitting your request to revoke in writing. However, please note that we are unable to take back any uses or disclosures made prior to your revocation.

Family Counseling Center understands that mental health information about you is personal. We comply with Louisiana State and Federal laws concerning personal health information. We provide a copy of our Notice of Privacy Practices in our lobby or a copy can be provided upon request.

I reviewed and understand this consent of the Family Counseling Center's Notice of Privacy Practices.

Print Client name: _____ Date: _____

_____
Signature of patient or all adults present

_____
Printed name(s) of all adults present

Relationship to the Client:_____

_____ _____
Signature of Family Counseling Center Representative File Name

Date of NPP_____