

Limitless Counseling Services (LCS) LLC  
2670 N. Columbus Street Suite G Lancaster, Ohio 43130  
Phone: (740) 901-1231 Fax: (740) 901-3021

**NOTICE  
CLIENT INFORMATION AND POLICY STATEMENT**

**NEW CLIENTS.** The following is important information about treatment, confidentiality, and office policy. It also contains summary information about the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). Please read it carefully and if you have any questions, your therapist will discuss them with you. HIPAA is a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. This Notice of this Agreement, which explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. You and your counselor can discuss any questions you have about these procedures in your first or second session. When you sign this document, It will represent an agreement between you, your counselor, and Limitless Counseling Services LLC. You may revoke this agreement in writing at any time. That revocation will be binding on us unless: we have taken action in reliance on it; if there are obligations imposed on us by your health insurer; in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have to us.

**CONFIDENTIALITY AND EXPECTATIONS TO CONFIDENTIALITY.** Federal and Ohio law require that issues discussed with a therapist be confidential. The information you reveal will not be discussed by the therapist with anyone, other than the exceptions listed below, without a signed authorization from you.

**LEGAL REQUIREMENTS.** The release of confidential materials may be legally required of your therapist in the following situations:

1. If your therapist believes you present a clear and substantial risk of harm to yourself (suicide) or others (homicide).
2. Suspected child, elder, and/or animal abuse or neglect.
3. Instances where the court subpoenas records.
4. If you file a complaint or lawsuit against your therapist or Limitless Counseling Services LLC.

**42 CFR STATEMENT.** Staff shall not convey to a person outside of the program that a client receives services from Limitless Counseling Services LLC or disclose any information identifying a client as an alcohol or other drug services client unless the client consents in writing for the release of information, the disclosure is allowed by a court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purposes. Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a client either at the program or against any person who works for the program. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local authorities.

**SUPERVISION.** If your therapist is under formal supervision, they will meet regularly for consultation and direction, and therefore, the supervisor will be familiar with you, your concerns, and the content of sessions. You can request a meeting with the supervisor at any time for any reason; including to discuss treatment and diagnosis issues.

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Clinicians employed by this agency are as follows:

Michelle Duncan LISW-S, LICDC	License #	I.1801304-SUPV and LICDC.101110
*Sabrina Kersey LCDC III, SWA	License #	LCDCIII.162108 and W.2000242
Ann Kennedy LISW-S	License #	I.0009445-SUPV
Megan Hughett LISW-S	License #	I.1901953-SUPV

**STAFF.** Your therapist may at some time practice with other mental health/behavioral health/addiction professionals and administrative staff. Protected information may be shared with these individuals for clinical and administrative purposes, such as scheduling, billing, and quality assurance. Any staff who may come in contact with Protected Health Information (PHI) are bound by the same laws of confidentiality.

If you learn at any time during your therapy that information may be requested from your therapist by a third party, e.g. physicians, lawyers, schools, or other mental health/behavioral health/addiction professionals, you need to inform your therapist as soon as possible. In such cases, you can waive your privilege of confidentiality by signing an authorization form. If at any point the therapist believes it would be useful to confer with other professionals, you will be asked to grant permission and to sign an authorization form.

**APPOINTMENTS.** Usually are scheduled bi-weekly to monthly; weekly when possible for at-risk clients. Because ongoing therapy is a negotiated process between you and your therapist, you will not be automatically rescheduled. Both you and your therapist need to evaluate the progress of your therapy periodically to determine the need for further appointments. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the therapists' ethical responsibility to end therapy when it is reasonably clear that you are not benefiting from treatment.

**CANCELATIONS.** If you find it necessary to cancel a scheduled appointment, a 24 hour notice is required. When less than a 24 hour notice is given, you may be responsible for a missed appointment fee. **The missed appointment fee is \$50 and will not be covered by insurance.** If you find you must cancel within 24 hours due to an unexpected circumstance (i.e. death in the family, car accident, extreme illness, natural disaster, etc.) your therapist can choose to waive the cancellation fee. If you fail to miss three (3) appointments without calling in advance to cancel within 24 hours you will be dismissed from the practice. This is to allow your therapist to meet the needs of all clients appropriately.

**EMERGENCIES AND AFTER HOUR CARE.** If known ahead of time, you must discuss any expectations you have for emergency treatment with your therapist and agree to develop and follow a written step-by-step plan. You should also be aware that you will be charged for after-hours care, whether on the phone or in person. If the need for crisis arises without warning, you may call and leave your therapist a voicemail message which is accessed daily. You can also use the Jituzu application and send a secure message in the client portal. If your crisis needs immediate attention, please call the 24 hour crisis line at **740-687-8255** or go to the nearest hospital emergency department. You can also text **988** or **741741 (4hope)** to be connected to a trained crisis counselor.

*Note: It is assumed that our clients are self-responsible, autonomous, functioning individuals, or in care of functioning adults, and not in need of day-to-day supervision. As private practitioners, we cannot assume responsibility for client's day-to-day functioning as can institutions nor can we be available 24 hours a day for crisis care.*

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**PROTECTED HEALTH INFORMATION RECORDS.** You should be aware that, pursuant to HIPAA, your therapist will keep Protected Health Information (PHI) about you in two separate categories. One set constitutes your **medical record** and the other is the **therapist psychotherapy notes**.

**MEDICAL RECORD.** Includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that are set for treatment, your progress towards these goals, your medical and social history, psychological testing, your treatment history, and past records that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself or others, you may examine and/or receive a copy of your medical record if you request it in writing and the request is signed by you and dated no more than 60 days from the date of submission. If we refuse your request for access to your medical record, you have the right for review, which we will explain at that time. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. You will be assessed a copying fee of \$5.00 as well as postage fee if mailing is required.

**THERAPIST PSYCHOTHERAPY NOTES.** These notes are for the therapists own use and are designed to assist them in providing you with the best treatment possible. While the contents of psychotherapy notes vary for client to client, they can include the contents of conversations, analysis of those conversations, and their impact on your therapy. They also contain particularly sensitive information that you may reveal that is not required to be included in your medical record. These psychotherapy notes are kept separate from your medical record. While insurance companies can request and receive a copy of your medical record they cannot receive a copy of your psychotherapy notes, nor require your authorization to release them as a condition of coverage. Your insurance company cannot penalize you in any way for your refusal.

**PATIENT/CLIENT RIGHTS.** HIPAA provides you with several new or expanded rights with regard to your medical record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your medical record is disclosed to others; requesting an accounting of disclosures of PHI; determining the location to which protected information disclosures are sent; having any complaints you make about agency policies and procedures records in your records; and the right to a paper copy of the agreement and our privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you. Your rights are as follows:

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
2. The right to receive services in the least restrictive, feasible environment.
3. The right to be informed of one's own condition.
4. The right to be informed of available program services.
5. The right to give consent or to refuse any service, treatment or therapy.
6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it.
7. The right or freedom from unnecessary or excessive medication, unnecessary physical restraint or seclusion.
8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures.

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9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies or photographs
10. The right to consult with an independent treatment specialist or legal counsel at one's own expense.
11. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations.
12. The right to have access to one's own client record in accordance with program procedures.
13. The right to be informed of the reason(s) for terminating participation in a program.
14. The right to be informed of the reason(s) for denial of a service.
15. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, disability or HIV infection, whether asymptomatic or symptomatic, or AIDS.
16. The right to know the cost of services
17. The right to be informed of all client rights.
18. The right to exercise one's own rights without reprisal.
19. The right to file a grievance in accordance with program procedures.
20. The right to have oral and written instructions concerning the procedure for filing a grievance.

If you have any complaints about professional services from a counselor, social worker, and/or family therapist, please contact:

The State of Ohio Counselor, Social Worker, and  
Marriage and Family Therapist Board  
77 South High Street, 24th Floor  
Columbus, Ohio 43215  
Phone: (614) 446-0912  
[www.cswmft.ohio.com](http://www.cswmft.ohio.com)

Ohio Chemical Dependency Professionals Board  
Vern Riffe Center  
77 South High Street, 16<sup>th</sup> Floor  
Columbus, OH 43215  
Phone: (614) 387-1110  
[www.ocdp.ohio.gov](http://www.ocdp.ohio.gov)

**PAYMENTS.** Payment at each session is expected. As a general rule, health insurance pay a portion of fees submitted. Until we have written documentation from your insurance company that your insurance deductible is met, we ask that you pay full fee at each visit. After your deductible is met, we ask that you pay the amount that is not covered by your insurance (co-pay) at the time of each session. If necessary, special payment arrangements can be made with your therapist. Credit cards accepted are Master Card, Visa, American Express, and Discover. There will be a \$40.00 returned check fee for each returned payment. Return check fees must be resolved before any appointments can be arranged. Missed appointment fees will also need to be paid before any appointment can be rescheduled.

In cases of divorce and blended families, we look to the custodial/residential parent or adult to make payments regardless of any court ordered agreements. The custodial/residential parent or responsible party will need to get reimbursement from other responsible parties.

Regarding billing statements, you are responsible for paying the "now due" amount on each statement. You will only be billed for your unpaid co-pay amounts, and any deductible your insurance reports you are responsible for. After sixty (60) days past due you will be billed a late fee of 10% of the amount due. An additional 10% will be assessed for each 30 days thereafter. After your last visit with your therapist, we

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expect you be current in having paid your co-payments, deductibles, and missed appointment fees. **For those required to complete mandated treatment, a letter of completion will not be submitted until all fees are paid in full.** After reasonable efforts to collect from you have been made, we reserve the right to turn your account over to a collection agency. This is a measure of last resort on our part and is made only when we think a client has not made a good faith effort to pay on their account.

**PRIVATE PAY.** It may be to your advantage to not use your insurance benefits due to the following reasons:

- **Privacy:** If your insurance company should ask for your complete medical record we have no control over how this information is used and who has access to it. Therefore, we cannot guarantee confidentiality once your information is turned over to your insurance company.
- **Control:** You have complete control over all information about you, who has it and what is done with that information (except for standard confidentiality exceptions related to safety and legal subpoenas.)
- You receive no psychological diagnosis.
- You have control over the frequency of your session and how long you feel/believe that you need to be in therapy.

**INSURANCE.** If you have health insurance, part of your therapy expenses may be covered. **You should contact your insurance company to obtain precertification or provide notification of services.** Your health insurance policy is a contract between you and your insurance company. When you call them please ask the following questions about your outpatient behavioral health care coverage:

1. Is your therapist a provider for your plan? If yes, how do I pre-certify visits? If no, how much does the policy pay for out-of-network visits?
2. How many visits are allowed per year?
3. What is the insurance company's usual and customary fee?
4. What is my deductible and has any of it been met?
5. Do I have a co-payment amount per session?

**It is important that you understand that any dispute with your insurance company is your responsibility.** You should be also aware that your contract with your insurance company requires that we provide them any information relevant to the service provided to you. We are required to provide the clinical diagnosis. Sometimes we are required to provide additional information such as treatment plans or summaries, or copies of your entire medical record. This information will become part of the insurance companies files and will probably be stored in a computer. Though all insurance companies claim to keep such information as confidential, we have no control over what they do with your information. This agency will provide you with a copy of any report we submit if you request it. By signing this agreement, you agree that we can provide requested information to your carrier.

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**FEES**

Description of Service	Fee
Initial Evaluation	\$175.00
Treatment in Lieu of Conviction Substance Abuse Evaluation	\$375.00
<b>Individuals</b>	
Individual session (60 minutes)	\$150.00
Individual session (45 minutes)	\$140.00
Individual session (30 minutes)	\$90.00
<b>Miscellaneous Fees (NOT Covered by Insurance)</b>	
Self-Pay Individual Initial Evaluation	\$150.00
Self-Pay Couples/Family Initial Evaluation	\$175.00
Self-Pay Individual Session (45-60 min)	\$95.00
Self-Pay Couples/Family Session (45-60 min)	\$125.00
Missed session fee (no 24 hour notice provided or a no call/no show)	\$50.00
Clinician Testimony (customary rate of clinician's time) **	\$150 per hour **
Phone Consultation (customary rate of clinician's time) **	\$150 per hour **
Medical Records ( <i>dependent on printed versus electronic</i> )	\$5 up to 20.00

Psychological testing is not currently available at LCS, but referrals can be made to another provider upon request or as needed.

**\*\*PAYMENT FOR COURT TESTIMONY** If the clinician is required to testify for any reason in court pertaining to treatment, you will be responsible for paying the fee for the amount of time spent in court, giving depositions, other court related business and travel time to and from the setting at the usual and customary rate of your counselor's time. If a clinician has to clear a full day (8-9 hours) of services to go to court, cost could be anywhere from \$1000-\$1500. **As a rule, insurance does not cover this expense.**

**\*\*PHONE CONSULTATIONS** Telephone consultations lasting 10 minutes or longer will be billed in 15 minute intervals based on the per hour rate of the counselor charge. **As a rule, insurance will not cover this fee.**

**RECORDS CUSTODIAN** In the event of your therapist's absence, incapacitation, or death, a records custody has been identified as required by law. **4757-5-09(I)** This person would be responsible for maintaining the records for the required 7 years after the date of the last session and would be knowledgeable about the transfer and custody of records.

**SESSION ETIQUETTE** We make the best effort to begin and end each session on time, but you may need to wait in situations where the client before you needs additional time. Your patience is appreciated and you will be given the same professional priority. When you arrive, it is not necessary to sign in. Please have a seat in the waiting area and your therapist will come to meet you. If providing regular or random urinalysis is a part of your treatment plan, please wait to use the restroom in case this is requested. Additionally, if you are under the influence for your scheduled appointment, you may be rescheduled. If you are impaired to the point in which you could pose a danger to yourself or others if you were to operate a motor vehicle, we will help you in contacting your emergency contact or support person to provide transportation from our agency.

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NOTICE  
CLIENT INFORMATION AND POLICY STATEMENT SIGNATURE PAGE

\_\_\_\_\_ YES \_\_\_\_\_ NO

I have received a copy of Limitless Counseling Services (LCS) LLC client information and policy statement including a summary of information from the Health Insurance Portability and Accountability Act (HIPAA).

\_\_\_\_\_ YES \_\_\_\_\_ NO

I agree that Limitless Counseling Services (LCS) LLC can provide the requested information to my health insurance carrier.

**Note Addendum:** LCS contracts with a billing agency, Stone Creek Medical Billing LLC, to submit and process claims. Client invoices will be sent electronically via email unless otherwise requested. All information will be kept confidential and adheres to all local, state, and federal mandates. **The client does recognize that by signing this form, they are solely responsible for all financial charges regardless of potential reimbursement by an insurance company, or any other third party.** The clients agrees to be treated by Limitless Counseling Services (LCS) LLC under terms of the Limitless Counseling Services (LCS) LLC Client Information and Policy Statement including the Health Insurance Portability and Accountability Act (HIPAA).

Client Printed Name: \_\_\_\_\_

Client/Responsible Party Signature: \_\_\_\_\_ Date \_\_\_\_\_

CONSENT FOR TREATMENT

I hereby do give consent for Limitless Counseling Services (LCS) LLC permission to provide treatment services for a behavioral health and/or substance abuse condition. Though I expect the care given to meet the customary standards, I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to as the result of such treatment and examination.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_  
(ALL clients age 14 years old +)

(Staff) Witness \_\_\_\_\_ Date \_\_\_\_\_

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CLIENT INFORMATION SHEET

CLIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PHONE: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

HOME ADDRESS

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

RELATIONSHIP STATUS: \_\_\_\_\_  
(I.E. MARRIED, SINGLE, SEPARATED, WIDOWED, DIVORCED, DOMESTIC PARTNER, POLYAMORY, NON-MONOGAMOUS, ETC.)

GENDER: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ TRANSGENDERED \_\_\_\_\_ OTHER: \_\_\_\_\_

PREFERRED PRONOUNS: \_\_\_\_\_ HE/HIM/HIS \_\_\_\_\_ SHE/HER/HERS \_\_\_\_\_ THEY/THEM/THEIR \_\_\_\_\_ OTHER  
(PLEASE DESCRIBE/DEFINE): \_\_\_\_\_

SEXUAL ORIENTATION: \_\_\_\_\_ HETEROSEXUAL \_\_\_\_\_ HOMOSEXUAL \_\_\_\_\_ BI-SEXUAL \_\_\_\_\_ PANSEXUAL  
\_\_\_\_\_ OTHER: \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ PRIMARY LANGUAGE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

STATUS: \_\_\_\_\_ FULL-TIME \_\_\_\_\_ PART-TIME \_\_\_\_\_ STUDENT \_\_\_\_\_ RETIRED \_\_\_\_\_ DISABLED \_\_\_\_\_ HOMEMAKER  
\_\_\_\_\_ UNEMPLOYED \_\_\_\_\_ OTHER: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REASON: \_\_\_\_\_

ANY CURRENT LEGAL OR PENDING CHARGES: \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_

PRIMARY CARE PROVIDER (PCP) NAME: \_\_\_\_\_ PCP PHONE: \_\_\_\_\_



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**INSURANCE INFORMATION**

**PRIMARY**

INSURANCE COMPANY: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_  
PLAN #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER DOB: \_\_\_\_\_  
POLICY HOLDER SSN: \_\_\_\_\_

**SECONDARY**

INSURANCE COMPANY: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_  
PLAN #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER DOB: \_\_\_\_\_  
POLICY HOLDER SSN: \_\_\_\_\_

YOUR INSURANCE MAY REQUIRE PREAUTHORIZATION FOR SERVICES. HAVE YOU CALLED TO INQUIRE?  
\_\_\_ YES \_\_\_ NO AUTHORIZATION NUMBER: \_\_\_\_\_ # OF SESSIONS \_\_\_\_\_

IS YOUR THERAPIST A NETWORK PROVIDER? \_\_\_ YES \_\_\_ NO \_\_\_ I DON'T KNOW.

**MEDICATIONS/MEDICAL CONDITIONS**

NAME STRENGTH/DOSE	FREQUENCY	REASON/MEDICAL CONDITION	PRESCRIBER

**ALLERGIES (FOOD OR MEDICATIONS)**

NAME/ITEM	REACTION (i.e. hives, swelling, rash, reacts to other medications, etc.)

*I agree that the information given above is accurate and true to the best of my knowledge. I understand that it is my responsibility to obtain the initial authorization from my insurance company. If I fail to do so, I understand that I would be full fee for services. Limitless Counseling Services (LCS) LLC bills insurance and verifies coverage as a courtesy (e.g. verification does not mean prior authorization). I understand that it is my responsibility to notify LCS immediately of ANY change in my behavioral health benefits. By signing below, I am acknowledging and agreeing to the previous statements. I am also recognizing that I have read and understand the insurance section of the policy statement for LCS.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party (if different from client) Signature: \_\_\_\_\_

**Teletherapy/Telehealth Informed Consent Form**

I, \_\_\_\_\_, hereby consent to engaging in teletherapy with Limitless Counseling Services LLC. I understand that “teletherapy” includes the practice of mental health and/or substance abuse care, delivery, diagnosis, consultation, treatment and education using interactive audio, video, or data communications of my medical/mental health information, both orally and visually. Limitless Counseling Services LLC is able to provide teletherapy service via Doxy.me and/or My Clients Plus and Jituzu software (HIPPA compliant video platform services). If there are additional methods that I prefer to conduct services, I will discuss this with my therapist to determine the best course of action.

I understand that I have the following rights with respect to teletherapy:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care of treatment nor risking the loss or withdrawal of any therapy benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

(3) I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of psychotherapy.

(4) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law.

(6) I understand that, per the ethical guidelines of the State of Ohio, teletherapy services can only be provided to those residing in the state of Ohio at the time of service.

(7) I understand that teletherapy is not always a covered service by my insurance plan, and it is my responsibility to check with my individual plan to determine if teletherapy is authorized for Out-of-Network coverage/benefits. Ultimately, I understand that I am responsible for all fees related to teletherapy that insurance does not cover.

(8) Teletherapy will be billed at the same rate of individual services.

(9) I have provided Limitless Counseling Services LLC with the following information and I have given my permission to utilize my email address as a method to contact me.

a) My home address

c) My email address

b) My phone number

d) A secondary emergency contact (name/phone #)

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I have read and understood the information provided above. I have discussed any questions I have with my provider, and all of my questions have been answered to my satisfaction.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**Tips for sessions through video chat:**

- *Ensure that your location is private and secure. Try to conduct your session in a room that allows you to separate yourself from distractions and any non-participants in the home who might overhear. Make arrangements for childcare if necessary.*
- *Make sure there is sufficient lighting. Dark and solid colored clothing works best and lowers risk of interference with video image. Avoid large pieces of jewelry that reflect light. Take off hats and sunglasses that limit the view of your face.*
- *Only use a Wi-Fi network that is secure via password protection, no public Wi-Fi when/if possible.*
- *Position yourself and camera so that you are visible from at least the waist up. If there are multiple participants, make sure everyone is in view.*

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Credit Card Authorization Form

*Please note that this form will be securely stored in your clinical file.*

I hereby authorize, **Limitless Counseling Services LLC**, to keep my signature and credit card information on file and to charge session fees (evaluation, individual, groups, family sessions, couple's counseling, urine screens, or other) to my credit, debit, or flexible spending account as filled out below for counseling services provided to: (Printed client's name)

---

\_\_\_\_\_ (initial) I understand that my counseling session will be charged via this form and not by swiping my credit card to collect fees for services.

\_\_\_\_\_ (Initial) I understand that this authorization is valid until it is cancelled in writing.

\_\_\_\_\_ (Initial) I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised.

\_\_\_\_\_ (Initial) I understand that charges for ongoing services will normally post within 72 hours of each session date and my session fee will be charged immediately. Additionally, I understand that a receipt will be sent to the email listed in my intake paperwork.

\_\_\_\_\_ (Initial) I understand that I am assuming session payment responsibility for the client above whose name is in the listed printed area, and if that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions unless authorized in writing by the client.

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I understand the conditions of this payment policy and agree to the conditions stated above. I agree that I am the owner or authorized user of the referenced credit card and authorize Limitless Counseling Services LLC to charge my credit card (listed below) for counseling services received.

X \_\_\_\_\_

Account Holder Signature

### **Cardholder Information**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

### **Credit Card Information**

Credit Card Type: \_\_\_ MasterCard \_\_\_ Visa \_\_\_ Discover Card \_\_\_ American Express

\_\_\_ Other: \_\_\_\_\_

Number: \_\_\_\_\_

Expiration Date (Month/Year): \_\_\_\_\_ Security Code (3 digit code) \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Limitless Counseling Services (LCS) LLC  
2670 N. Columbus Street Suite G Lancaster, Ohio 43130  
Phone: (740) 901-1231 Fax: (740) 901-3021

**PARENT/LEGAL GUARDIAN CONSENT FORM**

I give the staff at Limitless Counseling Services (LCS) LLC permission to treat my child/legal guardian to  
(name) \_\_\_\_\_ DOB \_\_\_\_\_.

Beginning on this date \_\_\_\_\_ and any following dates as needed.

If there is a court ordered custody document, I agree to provide a copy of this to the office immediately.  
\_\_\_\_\_ (initials)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Check all that apply:**

\_\_\_\_\_ My child can legally drive to and from counseling services.

\_\_\_\_\_ My child can walk to and from counseling services.

\_\_\_\_\_ My child can be transported by the following individuals:

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