Suzanne V. Perry, LCSW, LLC
7341 Jefferson Hwy., Suite E Baton Rouge, LA 70806
225-936-5512 therapy@suzieperry.com

HIPPA-Compliant Client Information and Office Policy Statement
Informed Consent

Welcome New Client:
Before signing any consent forms, please read these policies which are relevant to your counseling.

I. Goals:
My primary goal is to help you effectively address concerns that negatively impact your daily life or your ability to function effectively. It's your responsibility to play an active role in your counseling.

II. Appointments:
Appointments are scheduled for 55 minutes increments weekly or every other week. You may discontinue therapy at any time, but please discuss any decisions about your therapy with your therapist.

In the event of a crisis, you may contact me at 225-936-5512. If I am not available, leave me a voicemail or text, and then contact your physician, psychiatrist, or a care manager with your health insurance carrier. In the event of an emergency, go to your local hospital emergency room or call **911**.
In Baton Rouge, in the event of a crisis, you may also contact:

Baton Rouge Crisis Hotline, "THE PHONE:" 225-924-3900
COPE Team, Our Lady of the Lake Hospital: 225-765-8900

III. Confidentially:
Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentially. These situations include: 1) suspected abuse or neglect of a child, an elderly person or a disabled person, 2) when your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4) if your therapist is ordered by court to release information as part of any legal involvement, 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other health professional or family members on your behalf to facilitate or coordinate your care. ______ **Initial**

IV. Record Keeping:
Your clinical records are locked in a HIPPA-compliant, secure electronic system. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

V. Fees:

The fee for an Initial 60-minute Session is $130.00, which includes an administrate fee.
The fee for subsequent 50-60 minute sessions is $100.00.

If you use health insurance, your fee is adjusted according to contracted insurance discounts, your deductible, and/or your co-insurance or co-payment rates. This varies with different carriers and plans. It is your responsibility to familiarize yourself with your behavioral/mental health insurance benefits.

VI. Payments:

Payment is due at the beginning of each session. You are responsible for deductibles and co-payments/co-insurance. Services not paid for by the client's insurance are the client's financial responsibility. **I read and agree to this policy _______** (Initial.)**.** I accept cash or check only. You may make your check out to Suzanne or Suzie Perry, LCSW. There is a $25.00 charge for checks returned for insufficient funds. You may cancel or reschedule any time by calling or texting 225-936-5512 or online at www.therapyappointments.com. **I read and agree to this policy ______.**

VII. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, therapist, or any office policy please talk with me about it. If you do not feel your complaint has been resolved, you may also inform the social work licensing board.

VIII. Consent for Treatment:

By signing below, you are stating that you have read, understood, and agree to the above statements and questions were answered to your satisfaction. You have a right to a copy of this agreement.

Suzanne V. Perry, L.C.S.W., L.L.C.

INFORMED CONSENT

I accept, understand, and agree to abide by the contents and terms of this agreement. I consent to participate in counseling with Suzanne V. Perry, LCSW. This agreement is binding for one year or upon termination of counseling.

Printed Name of Client: ____

Client(s) Signature: ____

Date: ____

Therapist/Witness: ______________________________**Date:**__________________

AUTHORIZATION
RELEASE OF INFORMATION CONSENT FORM
HIPAA Compliant

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process health insurance claims, to obtain authorizations, or for insurance-required reviews or audits on my behalf for the services rendered me by Suzanne V. Perry, L.C.S.W.

Signed: ____ Date: ____________________

PATIENT/INSURED OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payments of medical benefits to SUZANNE V. PERRY, L.C.S.W., for services as described on Health Insurance Claims and submitted to my health insurance company on my behalf.

Signed: ______________________________________ Date: ______________________

Note: Insurance claims are filed through a HIPPA-compliant, secured, electronic system (www.therapyappointment.com).

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