2017

Thelma A. Costello, Ms, LMHC, PC
INTAKE INFORMATION

PATIENT'S NAME _____
(FIRST) (INITIAL) (LAST)
PARENTS OF MINOR ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PH. _____ CELL# _____ PATIENT'S DOB _____

INSURED'S REFERRALSOURCE

INSURED'S NAME AND ADDRESS SS# _____
INSURANCE COMPANY ADDRESS _____
GROUP# _____
EMPLOYER _____ INSURED'S
WORK# REFERRAL SOURCE _____
Insurance ID # _____

CONSENT FOR TREATMENT OFCHILDRENANDADOLESCENTS: I/ We consent that _____ may be treated as a client or clients by Thelma A. Costello, MS, LMHC.

Signature(s) _____ Date _____

CONFIDENTIALITYAND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for : a) information shared with our staff psychiatrist and b) information you and your child or children report about physical or sexual abuse; then by New York State Law, I am obligated to report this information to the New York Department of Children and Family Services, c) information shared with your insurance company to process your claims d) where you sign a release to have specific information shared e) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Thelma A. Costello, MS, LMHC will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ Date _____

Financial/Insurance issues: As a courtesy, we will bill your insurance company, HMO, or responsible party if you wish. I ask that at each session you pay your co-pay or 50% of the fee. **Cancellation policy; In the event you can not keep your appointment, please contact my office at (518-438-3139) or (518-495-7531), 24 hours prior to appointment. A cancellation fee/ no show fee of $60.00 will be charged to you for late cancellations (_____) initial.** If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00, we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18%APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to Thelma A. Costello, MS, LMHC. I sincerely appreciate your cooperation and at any time if you have any questions regarding insurance, fees, balances, or payments, please feel free to ask.

Signature(s) _____ Date _____