Discovery Counseling Services, LLC
13453 North Main Street, Suite 104
Jacksonville, Florida 32218
Phone 904-801-3794 | **Fax** 904-339-9967
contact@discoverycounselservices.com
www.discoverycounselservices.com

Discovery Counseling Services, LLC
1353 North Courtenay Parkway, Suite L
Merritt Island, Florida 32953
Phone 321-978-5122| **Fax** 321-978-5127
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Today's date:	Client Number:

How did you hear about us? (please check one box)
☐ Dr. _____ ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home or work
☐ Psychology Today ☐ Social Media ☐ Online ☐ Other: _____

Client Full Name:	☐ Male ☐ Female. ☐ Other	DOB:

Marital Status: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER	Employment Status: ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY ☐ OTHER	Student Status: ☐ FULL TIME ☐ PART TIME ☐ N/A

Client's Address:	_____ *Street Address*	Home phone no.: ( )	Cell phone no.: ( )
	_____ *City*	_____ *State*	_____ *Zip code*

Email Address:	OK TO DISCUSS SCHEDULING VIA EMAIL? ☐ YES ☐ NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL or TEXT? ☐ YES ☐ NO

IN CASE OF EMERGENCY

Name of closet relative or friend you would like us to contact in case of an emergency?	Relationship to client:	Phone No.: ( )

RESPONSIBLE PARTY (If different than the client).

Billing Full Name:	☐ RELATION TO CLIENT ☐ LEGAL GUARDIAN ☐ SPOUSE ☐ PARENT OF 18+ DEPENDENT ☐ OTHER

Billing Address:		City/State/Zip
Billing Phone:	LEAVE MSG? ☐ YES ☐ NO	Email Address *OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL?* ☐ YES ☐ NO

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake.

Primary Insurance Co.: *(Please give your insurance card to your front desk for copy.)*			Group No.:	DO YOU HAVE AN EAP? ☐ YES ☐ NO
Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:	Policy No.:	
Secondary Insurance Co.: *(Please give your insurance card to your front desk for copy.)*			Secondary Group No.:	
Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:	Secondary Policy No.:	

PRIVATE PAY Payment due IN FULL at the time of service.

SERVICE DESCRIPTION: ☐ Therapy ☐ Psychiatric Evaluation ☐ Medication Management	RATE/UNIT (TBD): $ /

ALL COPAYS AND PRIVATE PAYS ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

Policies with a DEDUCTIBLE or Out of Network Insurance Coverage REQUIRE A CREDIT CARD ON FILE	DO YOU HAVE AN HSA CREDIT CARD? ☐ YES ☐ NO NOTE: A deductible REQUIRES a non-HSA credit card on file as a back-up to any HSA card.
☐ Visa ☐ MC ☐ Amer. Exp. ☐ Discover	CARD NUMBER
EXP DATE / CVV CODE	*I hereby give consent to charge my credit card below for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me.*
CARD HOLDER SIGNATURE	DATE

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IMPORTANT SIGNATURES

CLIENT FULL NAME	DATE OF BIRTH

If client is a minor, please print name of parent/guardian(s) signing on behalf of the client:

PRINT FULL NAME	RELATIONSHIP TO CLIENT
PRINT FULL NAME	RELATIONSHIP TO CLIENT

MISSED APPOINTMENTS

_____ I am financially responsible for my attendance for all scheduled appointments, unless cancelled within **AT LEAST 24 HOURS**. I understand that I will be charged a **minimum of at least $75.00 for no-shows, missed and/or cancelations without AT LEAST 24-HOUR advance notice for appointments related to Medication Management and Psychiatric Evaluation services.** For appointments related to therapy I understand that a **minimum charge of $65.00 will be charged to my account for all no-show, missed and/or cancelations without AT LEAST 24-HOUR advance notice**. This charge is **NOT** covered by insurance.

CLIENT/GUARDIAN SIGNATURE _____ DATE _____

INSURANCE BILLING

____ I authorize Discovery Counseling Services, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Discovery Counseling Services, LLC. I understand that I am responsible for payment for services rendered by Discovery Counseling Services, LLC, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Discovery Counseling Services, LLC, immediately whenever I have changes in my health plan coverage.

LITIGATION LIMITATION

____ Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

RECORDS RELEASE

☐ I do not have a Primary Care Physician.
☐ I do not want Discovery Counseling Services, LLC, to release my information at this present time to any third parties.
☐ Discovery Counseling Services, LLC, to release my information to _____.

CLINICAL STAFF RELEASE

____ I understand that as part of professional clinical consultation, my situation may be reviewed using general clinical information, and that my therapist will obtain a signed Release of Information (ROI) prior to discussing specific details of my situation.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

____ I am consenting to treatment and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practice (HIPAA).

My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all of the terms and conditions of the Counseling Policies. If I have questions, the information has been explained and/or summarized for me.

SIGNATURE(S) (CLIENT OR LEGAL GUARDIAN)	DATE
WITNESS SIGNATURE	DATE

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____ authorize Discovery Counseling Services LLC to:

_____ Release to:

_____ Obtain from:

_____ Exchange with:

PRIMARY CARE PROVIDER/CLINIC/AGENCY/PERSON(S)

ADDRESS | CITY/STATE | ZIP-CODE

PHONE | FAX

THE FOLLOWING INFORMATION PERTAINING TO MYSELF:

_____ TREATMENT SUMMARY _____ HISTORY/INTAKE ____ DIAGNOSIS

_____ PSYCHOLOGICAL TEST RESULTS _____ PSYCHIATRIC EVALUATION/MEDICATION HISTORY

_____ DATES OF TREATMENT ATTENDANCE _____ OTHER (SPECIFY): _____

FOR THE PURPOSE OF:

_____ evaluation/assessment and/or coordinating treatment efforts.

_____ other (specify): _____

*This consent will automatically expire one **(1) year** after the date of my signature as it appears below, or on the following earlier date, condition, or event.*

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Social Security #: _____

SIGNATURE OF CLIENT | DATE | DOB: _____

SIGNATURE of LEGAL GUARDIAN *(IF UNDER THE AGE OF 18-years-old)* | DATE | RELATIONSHIP TO CLIENT

WITNESS SIGNATURE | PRINT NAME | DATE

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Name: _____ DOB: _____ Date: _____

CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, therapists, specialists, and/or subspecialists. The information may be used for diagnosis, evaluation, medication management, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and/or video
- Output data from medical devices and sound video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her practitioner's office (or at a remote site) while the provider obtains test results and consults from healthcare practitioners at distant and/or other remote sites.
- More efficient psychiatric evaluation and medication management services.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical services, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- If receiving psychiatric services, in rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My prescribing provider has explained the alternatives to my satisfaction.
5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

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Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize _____ (name of provider) to use telehealth in the course of my diagnosis and treatment.

Signatures:

_____ _____

Signature of Client and/or Client's Representative/Legal Guardian | Date of Signature

_____

Relationship of Representative to Client

_____

Signature of Witness *(required if client is unable to sign)*

Refusal: I refuse to participate in a telehealth services as described above.

_____ _____

Signature of Client and/or Client's Representative/Legal Guardian | Date of Signature

I have been offered a copy of this consent form (patient's initials) _____

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CONSENT FOR ELECTRONIC MESSAGES

The Telephone Consumer Protection Act (TCPA) requires your consent to receive electronic messages from this office (text, telephone, and/or email).

I, _____ consent to receive the following forms of messaging: *(please check choices)*

☐ text

☐ telephone

☐ e-mail

I understand that I can choose to withdraw this consent at any time by signing to opt out.

Signature _____ Date _____

I, _____ choose to opt out/withdraw my consent for the following forms of electronic messaging: *(please check choices)*

☐ text

☐ telephone

☐ e-mail

Signature _____ Date _____

This documents our compliance with the Telephone Consumer Protection Act (TCPA).

Please note that it is our practice's responsibility to comply with the TCPA and obtain the consent of each patient and/or client whom wishes to receive SMS, text and/or voice messaging prior to sending such messaging.

***For questions and/or concerns please speak with your provider and/or staff.*

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FOR CLIENT TO TAKE HOME - COUNSELING POLICIES

Please carefully read through the following Counseling Policies. This document contains important information about our professional services and business policies, as well as responsibilities and expectations of you as the client. When you sign the IMPORTANT SIGNATURES page of our documents, it represents your understanding of all the rules and responsibilities of both the client and the therapist, in addition to understanding the financial terms and agreements.

WELCOME TO DISCOVERY COUNSELING SERVICES LLC!

We are a professional mental health counseling group where your therapist maintains his or her private practice. Within this model, the Private Practice is your primary point of contact for scheduling & account management (payment, statement/receipt requests, & billing questions). Your therapist _____, can be reached at the following number 321-978-5122 or _____ and/or email address **contact@discoverycounselservices.com**. Our business office provides administrative support to your therapist. To update your insurance information or to cancel and/or reschedule your next appointment, please contact the Office Manager at 321-978-5122.

What is therapy and how does it work?

Therapy is the process of solving emotional problems by talking with a professional trained to help you achieve a more fulfilling individual life, marital/couple relationship, or family relationships. The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life.

The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. In some instances, talking about your difficulties may exacerbate your symptoms, however over time you should see an improvement.

Generally speaking, the relationship between the therapist and the client is the most accurate predictor of success in the therapy. As the client, you have the right to ask your therapist questions about his or her qualifications, professional background, and therapeutic orientation. If at any time during the therapy you have questions about whether or not the treatment is effective, feelings about something your therapist has said or suggested or need clarification of our goals, do not hesitate to bring this up in your session.

You can end therapy at any point you wish. Usually therapy pursues specific goals and you and your therapist will discuss together an appropriate termination process. A final session is strongly recommended for closure.

INTAKE APPOINTMENT

Since your therapist is your primary contact, you will not need to check in with a receptionist upon arrival. Please take a seat in our waiting area and your therapist will greet you for your appointment. Please bring the following REQUIRED items to your intake appointment:

- Completed and Signed Counseling Policies forms
- Completed Personal History form
- Completed PHQ (adults) or SDQ (minors)
- Photo ID (of legal guardian, if client is a minor)
- Insurance card(s) – *also bring MA card if you have one*
- Payment for copay or other financial responsibility (cash, check and/or major credit card)

If you are unable to complete, or forget to bring your forms, please arrive a minimum of 15-20 minutes early to complete a new Personal History form located in the wall file in the waiting area. The time allotted for the appointment cannot be extended due to incomplete forms. All forms will be reviewed during your intake session and the remaining time will be spent talking about what brought you in for counseling. Your therapist will focus on hearing your story and asking questions to better understand your particular struggle and/or situation. This is also a time to measure how comfortable this feels and if this is a good "fit" between you and your therapist.

All forms will be reviewed during your intake session and the remaining time will be spent talking about what brought you in for counseling. Your therapist will focus on hearing your story and asking questions to better understand your particular struggle and/or situation. This is also a time to measure how comfortable this feels and if this is a good "fit" between you and your therapist.

By the end of your first session, you can expect some feedback from the therapist and both of you will agree on a "game plan" for therapy. If you have any questions, feel free to ask your therapist during your appointment.

IN CASE OF AN EMERGENCY

Your therapist is not available for after-hours crisis or emergency situations. In a crisis or an emergency, please call 911 or go to the nearest emergency room.

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CONFIDENTIALITY POLICY

The staff and therapists at Discovery Counseling Services, LLC have an obligation to respect your right to confidentiality for the information you share within this clinical setting. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law.

The State of Florida laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality:

- We are obligated to report any maltreatment of minors or vulnerable adults. This includes physical abuse, sexual abuse or neglect.
- We are obligated to report any prenatal exposure to controlled substances.
- We are obligated to report any serious harm you intend to inflict on yourself or another.
- We are obligated to share information if directed by Court Order to conform to state or federal law, rules or regulations.
- We are obligated to share information with licensing boards, which is pertinent to a disciplinary proceeding involving a provider.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. Minor clients have rights to complete confidentiality in obtaining counseling for pregnancy & associated conditions, sexually transmitted diseases, and information about drug and alcohol abuse. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. However, Discovery Counseling Services LLC, and group therapists are not responsible for any breaches of confidentiality by group members.

Master's prepared therapy interns are an integral part of our counseling team and are obligated to abide by the relevant code of ethics and HIPAA privacy guidelines regarding confidentiality when participating in individual supervision with a primary clinical supervisor (licensed mental health professional), bi-monthly peer supervision staffed by our licensed clinical team, impromptu individual supervision and consultation by other licensed staff clinicians, as well as appropriate supervision within their academic community. There are instances in which administrative individuals associated with Discovery Counseling Services LLC have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc.

In keeping with standards of practice, your therapist may consult with other mental health professionals within this private practice regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your therapist will maintain confidentiality and protect your identity by not using real names or any identifying information. Therapists seeing members of your family or your significant others will obtain a signed Release of Information (ROI) prior to discussing specific details of your situation.

TELEPHONE & EMAIL COMMUNICATION

Voicemail is available between sessions. Messages will be returned as soon as possible during business days. Please do not rely on your therapist's voicemail in times of crisis or for an emergency.

A prorated charge is applicable to time spent with you on the telephone by your therapist beyond appointment scheduling or similar matters (lasting more than 15 mins). Telephone sessions between sessions may be scheduled in advance, based on availability of both parties. Therapy sessions conducted on the telephone are not billable to insurance.

Email should ONLY be used for scheduling purposes and may not be checked on a daily basis. Email correspondence is not considered to be a confidential medium of communication and your therapist is not responsible for any information transmitted via email.

INSURANCE BILLING

We are patiently waiting to be providers for several insurance providers. Currently, we are in network with Cigna, BCBS, Humana, Tricare, Aetna, Medicaid and most EAP programs. Currently in the process of getting credentialed with other health care insurances. We greatly appreciate your patience.

You must notify us in advance of your first appointment if you intend to use an Employee Assistance Program (EAP). Once services have been provided under insurance, we will not bill your EAP.

Once your appointment has been scheduled, we will verify your coverage and obtain any necessary authorizations. Verification of coverage is not a guarantee of claim payment. Coverage is subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company.

It remains your responsibility to understand your plan's limitations, deductibles and exclusions. For benefit coverage questions, please call the customer/member service number on the back of your insurance card. We have no authority to make specific representations to you regarding coverage of services.

It is your responsibility to provide us with updated information when your insurance policy changes or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for paying the amount of the denied claim.

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If you attend any appointment without verification of your current insurance coverage, you are responsible to pay the private pay fee for services at the time of your visit.

There may be instances in which you will need to communicate directly with your insurance company to ensure a smooth billing process. If your insurance requests information regarding Coordination of Benefits (CoB) or Pre-existing Conditions, please promptly return any forms or call your insurance company directly to follow up. Once they request this information from you, all claims deny, and become your full financial responsibility until you provide it. Please call us at 321-978-5122 to let us know you have resolved any CoB or Pre-existing Condition requests so that we can have your insurance reprocess the denied claims immediately.

ACCOUNT RESPONSIBILITY

Because we are a "fee for service" provider, billing statements from Discovery Counseling Services, LLC, will NOT automatically be sent - should you need a statement or itemized receipt, please inform your therapist, and we will provide this for you upon request.

Per your agreement with your insurance company, it remains your responsibility to *immediately* pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you. This payment is to be collected by your therapist.

We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract, we have with your insurance company.

Cost estimation tools provided by your insurance company allow the collection of coinsurance and deductible amounts **up front at the time of service,** rather than waiting until after the claim is processed. This collected payment is based on an estimate of your out-of- pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and you receive an explanation of benefits (EOB). Any overpayments will be applied to ongoing balances or refunded within 30 days of claim processing. Any underpayments must be paid by mail or at your next scheduled appointment (if scheduled appointment occurs within 1 week of receiving your EOB).

To ensure proper credit, please make checks payable to *Discovery Counseling Services, LLC*. There will be a $40.00 fee for returned checks. Thereafter, payment will only be accepted in the form of cash, credit card or money order.

You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Should you default on any payment obligations, we reserve the right to forward your information to collections, and an additional 30% may be assessed to cover the costs of this action.

We are not obligated to provide continuing services in the event that Discovery Counseling Services, LLC, is named as a creditor in any bankruptcy filing.

MISSED APPOINTMENTS

We realize that on occasion you will not be able to make a scheduled appointment. However, please remember that your therapist has reserved this time for you alone, so our policy is to charge unless cancelled within **AT LEAST 24 HOURS**. Please remember that you will be charged a **minimum of at least $75.00 related to Medication Management and Psychiatric Evaluation appointments for no-shows, missed and/or cancelations without AT LEAST 24-HOUR advance notice.** For appointments related to therapy, I understand that a **minimum charge of $65.00 will be charged to my account for all no-show, missed and/or cancelations without AT LEAST 24-HOUR advance notice**. It is up to your therapist's discretion to require more than a 24-hour notice or to charge a higher rate for missed appointments. This charge is **NOT** covered by insurance and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments.
** *Clients with more than one missed appointment may be subject to same day scheduling and/or termination of care.*

PREPARATION OF FORMS AND REPORTS

These require chart review and often, discussion with the client. A prorated charge is applicable to time spent and is **NOT** billable to your insurance.

RELEASE OF RECORDS

Most of the information a clinician collects about you will be classified as confidential. However, when insurance is involved, Discovery Counseling Services, LLC, does not have control over and cannot assure its clients of confidentiality. That means employees of the insurer and employees of contracted organizations of the insurer have access to your chart. This is provided for in the insurance policy between you and your insurance company. The client record is legally the property of Discovery Counseling Services, LLC. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client's well-being. Information can be released to others only upon written informed consent of the client. In a few cases, information is unavailable to a client. Certain confidential data may be available only to the clinician and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children or vulnerable adults. In the event of request for transfer of records, the records will be forwarded upon completion of a Release of Information form.

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COURT & LEGAL PROCEEDINGS

DCS does NOT provide disability determination, custody studies or handle court issues.

- DCS providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults. DCS services are designed to assist in alleviating problems through individual or relational psychotherapy. DCS providers are not trained for, nor do they maintain records with the intended purpose of court involvement.
- In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition.
- Should we be called to court by a judge court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under law for our services.
- In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) at the rate of $250.00 per hour, rounded to the nearest half hour.
- The client further agrees to pay a retainer fee of $2,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist at DCS to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. **My informed consent signature shows that this litigation limitation is clearly understood and agreed upon.**

CLIENT BILL OF RIGHTS

DCS does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status. Every client:

- shall be informed prior to, or at the time of, the intake appointment of services available at DCS and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
- can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- shall have the freedom to place grievances and recommend changes in policies and services to DCS staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Florida have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct. Every client:

- has the right to be informed of and to refuse to participate in any experimental research.
- may expect courteous treatment and to be free from verbal, physical, or sexual abuse by DCS staff.
- has the right to a coordinated transfer of care when there will be a change of providers.
- may assert the client's right(s) without retaliation.

Client has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client's health insurance (if any).

COMMENTS, QUESTIONS & CONCERNS?

We value your opinion and strive to provide the best service possible. If you would like to share your comments, questions, or concerns, please contact Discovery Counseling Services, LLC, at 321-978-5122, or email, contact@discoverycounselservices.com.