Cynthia L. Collins-Clark, M.Ed., LPC, NCC

1616 E. 19th Suite 404 Edmond, Oklahoma 73013 405-474-3467

www.clarkcounsel.com or clarkcounsel@cox.net

Below is a listing of fees and office policies. Please print all forms and complete them prior to your initial appointment. If you have any questions, don't hesitate to call!

1. Office Fees*:

Initial Assessment (60 minutes)	$120.00
45 minute session	90.00
60 minute session	120.00
Family Therapy (45/50 minutes)	120.00
Family Therapy (75/80 minutes)	150.00
Group Therapy (per participant)	40.00
Phone Consultation	60.00
No show Appointment	priced as scheduled
Written Reports (per hour)	120.00
NOTE: Sliding Scale for	
Military, Veterans and Families	40.00 individual
or co-pay, whichever is the lowest	80.00 family

2. Payment/Co-Payment is due when services are rendered. Client is responsible for full payment until the deductible is met, at the time of service. There will be a $15.00 service charge for any returned checks.
3. Any appointment may be cancelled within 24 hrs. at NO CHARGE. The 1st missed appointment is half the scheduled fee and the 2nd missed appointment is the full scheduled fee. This charge will be payable prior to the next scheduled session and CANNOT be billed to your insurance company.
4. If you are late for an appointment, the session will terminate at the scheduled time.

Current Insurance Accepted: BCBS, Health Choice, United Behavioral Health, and Value Options. (*Some insurance plans require paper claims. I use electronic billing only. If your plan requires paper claims, payment will be due at the time of the session and I will offer information how you may file for your insurance reimbursement.)*

NOTE: During the course of your treatment, should you have an emergency situation, please observe the following instructions:

1. Should your emergency require immediate care, please go to the nearest hospital emergency room; have their staff contact your Primary Care Physician and myself and/or call 1-800-273-8255.
2. For any other emergency situations, please call 474-3467. If I am not available, please leave a brief message and how I can reach you and call 1-800-273-8255.

*** Prices effective January 1, 2016 for all clients.**

PATIENT REGISTRATION

Today's
Date:_____SS#_____
Patient's name:_____
Address: _____City:_____
State: _____ Zip: _____ Home Phone: _____
Email Address:_____Date of Birth:_____
Patient Employer: _____ Phone:_____
Family Physician: _____ Phone: _____
Person to contact in
Emergency:_____Phone:_____

INSURED/RESPONSIBLE PARTY INFORMATION
Please complete this section regardless of insurance coverage.
Full name of insured:

_____
Relationship: _____ Occupation: _____
Employer Address: _____ Phone: _____
Insured's SS#: _____ Birth Date:_____State_____
Insured's Primary Insurance Co.: _____
ID#_____Insurance Phone#_____
Group No: _____ Secondary Ins. Co.: Yes No
Company: _____ID#_____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided.
There will be a $15.00 service charge on all returned checks.
You must cancel your appointment 24-hrs. in advance to avoid being charged.

Signature: _____Date: _____

STATEMENT OF DISCLOSURE
LICENSED PROFESSIONAL COUNSELOR

Cynthia L. Collins-Clark, M.Ed., LPC
License #2218
1616 E. 19th Suite 404
Edmond, OK 73013
405-474-3467

Philosophy and Approach:

The core of my counseling philosophy is based on a cognitive-behavioral theoretical approach. Counseling techniques include, but are not limited to, acceptance, clarification, reflection, empathy, identifying and stressing client strengths, evaluating and setting limits and feedback. In addition, the use of psychoanalytic interpretations, interpretive dream work, free association, systematic desensitization, relaxation therapy, visualization, early memory work, EMDR, 12-step work, PREP for couples and other techniques may be used. Behavior modification plans may also be developed.

All techniques are founded on and supported by, the identification and openness to the spiritual center within the client. Prayer or a moment of silence is used to open and close each session.

Education

I hold two Masters Degree's in Education, one specializing in Secondary Education and the other in Counseling and Guidance. Both degrees and additional coursework required for licensure are from the University of Central Oklahoma.

To maintain my license, I am required to participate in annual continuing education, taking classes dealing with subjects relevant to this profession.

Note

You may contact the State Board of Health Behavioral Health Licensure, 3815 N. Santa Fe, Suite, 110, Oklahoma City, OK 73118 405-522-3698 if you have questions or concerns.

_____ _____
(Signature of LPC) (Date)

_____ _____
(Signature of Client) (Date)

INFORMED CONSENT

Counseling Relationship A counseling relationship needs to function under professional guidelines for it to provide maximum benefits. To avoid dual relationship issues, our contact will be limited to counseling sessions or other professional concerns such as scheduling and emergencies (this includes no personal or social media relationships for 2 years after termination of therapy). If there is contact in another setting, I will protect your confidentiality by allowing you to initiate any interaction that occurs. **I do not have an encrypted message system. If you choose to text or email it may be accessible to others and may be considered a waiver of Therapist-Client Privileged information (this means that you recognize that I cannot protect any electronic communication and that if it may void the confidentiality agreement).**

Effects of Counseling While benefits are expected from counseling, no specific outcomes are guaranteed. Part of the process is to establish goals and a plan for reaching them. Your time in counseling may lead to major changes in how you choose to view important issues in your life. The exact nature of these changes is not predictable and could affect significant relationships, your job, and your view of yourself. During the counseling process, there may be periods of increased discomfort and strong feelings. The intent is to facilitate the best possible outcome based on your goals for counseling.

Client Rights The length of time in the counseling process varies from a few sessions to several years depending on the needs and goals of the client. You are in complete control of this decision and may terminate the counseling relationship at any time. However, I ask that you participate in a termination session when that decision is made. You may, at any time, refuse or discuss modifications of any counseling technique or suggestion.

I am committed to providing my services in a professional manner consistent with accepted legal and ethical standards. If, at any time, you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, we can consult with another counselor or I will help you locate another counselor to continue the counseling process. If you feel that any ethical violations have occurred, you may contact the State Board of Health Licensure, 405-522-3698.

Referrals There may be times that I refer you to other professionals to provide services that will enhance our work. If, at any time, you and/or I believe that a referral to another counselor is needed, I will provide you with the names of other counselors who may assist you. You will be responsible for contacting and evaluating those referrals. During your time in counseling, you will be expected to allow contact with other professionals such as physicians, counselors and psychiatrists to maximize quality of care.

Weather Cancellations My office will be closed any time that the Okla. City, Edmond, or Mid Del Oklahoma, schools are closed.

Confidentiality Most communication in the counseling relationship is confidential. However, the following limitations do exist:

1. The use of case records for the purposes of supervision or professional development. Your permission will be requested if this is desired. If I determine that you are a danger to yourself or others. This may include physical restraint from self-harm and requesting emergency assistance and transportation to a medical or psychiatric facility.
2. You disclose abuse or neglect of a child, elderly or disabled person.
3. You disclose sexual contact with another mental health professional.
4. I am ordered by a court to disclose information or otherwise required by law to disclose information.
5. You direct me to release your records. A "Release of Information" form will be used for this purpose.
6. Your insurance or third party payer requests information to authorize coverage of services.

The client agrees to hold the counselor harmless for the disclosures and consequences of sharing information with third party payers.

Children over the age of sixteen are considered legal adults when involved in mental health services. Therefore, the same laws as adults govern confidentiality. Before the age of 16, communication of confidential information between counselor, client, and parents or legal guardians is at the discretion of the counselor.

In marriage or family counseling, I will keep confidential, within the limits noted above, information disclosed without your family member's knowledge. However, open communication among family members is encouraged and I reserve the right to terminate our counseling relationship if I judge the counseling process to be non-therapeutic.

Records All records become of the property of Cynthia L. Collins-Clark, LPC, NCC. Only my official designee or I may disclose copies of written patient information or release client information over the phone. Adult client records are disposed of in five years after the file is closed. Minor children are disposed of seven years after the client's eighteenth birthday. All records are electronically stored and encrypted.

In the event that Cynde Collins-Clark, LPC is no longer available for counseling (emergency, death, etc.), please contact your insurance company for a new referral. Summary records may be obtained by writing to jclark113@cox.net, who holds power of attorney.

By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

_____ _____

(Client Name) (Date)

SELF-ASSESSMENT

Name _____Date_____

What is happening in your life which resulted in this appointment?_____
What would you like to see accomplished in therapy?
_____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

___Depression
___Low Energy
___Low Self-Esteem
___Poor concentration
___Hopelessness
___Worthlessness
___Guilt
___Sleep disturbance (more/less)
___Appetite disturbance (more/less)
___Thoughts of hurting yourself
___Thoughts of hurting someone
___Isolation/social withdrawal
___Sadness/loss
___Stress
___Chills/hot flashes
___Tingling/numbness
___Fear of going crazy
___Phobias
___Thoughts racing
___Easily agitated
___Excessive behaviors (spending/gambling/eating)
___Previous suicide attempt
___Feeling that you are not real
___Feeling that things around you are not real
___Lose track of time
___Unpleasant thoughts that won't go away
___Anger/frustration
___Easily agitated/annoyed
___Defies rules
___Blames others
___Argues
___Excessive use of drugs and/or alcohol
___Excessive use of prescription medications
___Blackouts
___Physical abuse issues
___Sexual abuse issues
___Spousal abuse issues
___Fear of dying
___Nausea
___Obessions/Compulsive Behaviors
___Can't hold on to an idea
___Not thinking clearly/confusion
___Delusions/hallucinations
___Veteran or Family of Veteran (circle one)

Other problems/symptoms:_____

Previous outpatient therapy? Yes No If yes, with whom:
_____
Previous psych hospitalizations? Yes No If yes, with whom
_____
Current medications and dosages:
_____

Illnesses and Medical Problems

Please mark with an "X" any of the following illnesses and medical problems you have had and indicate the year when each started (approx. if you are not sure). The more information you provide, the better we can address your needs.

Illness	X	Year	Illness	X	Year
Eye or Eyelid infection			Venereal Disease		
Glaucoma			Genital Herpes		
Other Eye Problems			Breast Disease		
Ear Condition			Nipple Drainage		
Deafness or Decreased Hearing			Headaches		
Thyroid Problems			Head Injury		
Strep Throat			Stroke		
Emphysema			Black Outs		
Pneumonia			Dizziness		
Allergies, Asthma			Mental Conditions		
Hay Fever			Arthritis		
Nose Bleeds			Gout		
Tuberculosis			Cancer/Tumors		
Other Lung Problems			Bleeding Tendency		
Difficulty Breathing			Diabetes		
High Cholesterol			Measles/Rubella		
Arteriosclerosis			Polio		
Heart Attack			Mumps		
Chest Pain			Scarlet Fever		
Irregular Heart Beat			Chicken Pox		
Heart Murmur			Mononucleosis		
Other Heart Conditions			Eczema		
Stomach/Duodenal Ulcer			Psoriasis		
Vomiting			Skin Rash		
Weight Loss			Open Wounds		
Weight Gain			Infection		
GERD			Muscle Stiffness		
Difficulty Swallowing			Muscle Weakness		
Diverticulosis			Muscle Pain		
Colitis			Bone Fracture		
Other Bowel Problems			Bone Stiffness		
Blood in Stools			Dental Problems		
Diarrhea			Other		
Hemorrhoids					
Easily Fatigued					
Hepatitis					
Liver Problems					
Gallbladder Problems					
Hernia					
Kidney or Bladder Disease					
Prostrate Problem					
Ovarian Problem					
Last Menstrual Period					
Last Pregnancy					
Menstrual Flow Pattern					