CLIENT PLEASE KEEP
Breaking Free Counseling Services
Client Orientation

PROGRAM RULES:

1. Breaking Free Services, Inc. will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or "search and seizure" methods will be employed.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from client's financial institution (ie, NSF fee from bank) there will be a $20 fee collected prior to the next appointment.
4. Client's must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should client be under the influence of substances other than prescribed medication, the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual, agreed upon fee.
5. **Except in cases of emergency, cancelations must be made 24 hours in advance; failure to give 24 hour notice will be considered a "no show" and billed accordingly, ie, at the usual agreed upon fee.**

Program Procedures:

1. Client's rights to confidentiality will be observed at all times, with the following exceptions:
In case of probable imminent danger of self or others.
In cases of child abuse, including sexual abuse.
Communicable diseases must be reported by the counselor to the appropriate county health department.

Or

When you, the client, request that we relesse information. Information is shared with the other entities (ie, doctors, insurance companies, etc.) when your requested by signing an authorization to release information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.

2. We reserve the right to release only a treatment summary instead of detailed case notes.
2A. A minimum requirement of 72 hours is needed for medical records, once a written request is received.

3. The undersigned will neither individually or jointly involve the therapist or Breaking Free Services, Inc. (and it's staff) in any litigation. The undersigned will neither request nor require that Breaking Free Services, Inc. or the therapist provide testimony in court. The reason for t6his is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purposes, the services of a person outside of Breaking Free Services, Inc. must enlisted.

Counseling Recordings / Artwork: The use of videotaping or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or therapist training purposes. Your confidentiality is protected and recordings are erased after every session unless your permission is given for another use. In the case of video or audio taping, you would be informed ahead of time and your written permission will be needed. The use of photography typically involves pictures of children's [lay structures (ie, sand trays, building blocks, etc.) or pictures of the children with our therapy pet. Children are offered copies of the pictures and this often helps them extend the therapy program to home and school. Artwork is sometimes used for training purposes, but the child's identity is protected. If you have any questions about this, please ask your therapist.

Hours of Operation By appointment. Currently nights and some weekends are available.

Afterhours Emergencies In the event of behavior health emergency, contact 911 or go to the nearest crisis center: The Harbor Behavioral Health Center

Payment of Fees or Service

1. We accept cash, check and all major credit cards. Insurance reimbursement is not available at this time.
2. If a check is returned for insufficient funds, you will be required to pay any bank service charges in addition to the check amount.

Acknowledgement / Consent:

I authorize the Release of Medical Information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Breaking Free Services, Inc. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Breaking Free Services, Inc. of any changes to my insurance information, address, telephone number, and any relevant changes.

By signing this form, I am acknowledging receipt of a copy of this paper and agreement to the orientation terms and conditions as provided by Breaking Free Services, Inc.

(Print Client's Name)

/ /

(Client's Signature) (Date)

/ /

(Parent/Legal Guardian's Signature – if a minor) (Date)