

Catherine M Melo, MSW, LCSW
Licensed Clinical Social Worker
4001 Main St., Ste 313
Vancouver, WA 98663
P: 503-360-4909

New Client Confidential Information

Client Information

Date: _____

Name _____ Gender/Pronouns _____

Address _____ Marital Status _____

City _____ State _____ Zip _____ DOB _____

Cell Phone _____ Email _____

Home Phone _____ Employer _____ Occupation _____

Partner Information

Name _____ Gender/Pronouns _____

Address _____ Marital Status _____

City _____ State _____ Zip _____ DOB _____

Cell Phone _____ Email _____

Home Phone _____ Employer _____ Occupation _____

Insurance Information

Insurance #1

Insurance #2

Insurance Co. Name _____

Insured's Name _____

Insured's ID# _____

Group Name/No. _____

How did you hear about my
office? _____

What are the benefits you wish to achieve from
counseling? _____

I, the undersigned, assign insurance benefits directly to Catherine M Melo, MSW, LCSW, if any, otherwise payable to me for services rendered. I hereby consent to the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am responsible for all charges incurred for client regardless of insurance coverage. I understand and agree that all accounts are due and payable at the time of service and that insurance is being billed as a courtesy. In insurance assigned cases, Catherine M Melo, MSW, LCSW, agrees to accept the charge determination of the insurance carrier as the full charge and the client is only responsible for the deductible, co-insurance and non-covered services. My insurance carrier may only pay for services it determines are "reasonable and necessary". If my insurance carrier denies payment for these services, I agree to be personally responsible for payment.

I understand that appointments canceled with less than 24 hour notice will be billed for the time reserved.

Signature of Responsible Party _____

Date _____

Catherine M Melo, MSW, LCSW
Licensed Clinical Social Worker
4001 Main St., Ste 313
Vancouver, WA 98663
P: 503-360-4909

CLIENT POLICIES

Confidentiality: Discussions occurring in psychotherapy are confidential or privileged communication. It is important that it is the client who holds the privilege. I cannot discuss your case with anyone else without your written consent.

Legal exceptions to confidentiality include:

- When a client is a danger to themselves or others;
- When there is reason to believe that a minor, elderly or disabled person was a victim of a crime, neglect or sexual/physical abuse;
- When ordered by a judge to release information
- When necessary to pursue non-payment of your bill or services rendered;
- When a client initiate legal action or makes a complaint against the therapist.

Length of appointments: Typical counseling appointments are set for 50 minutes.

Timing of Appointments: Therapist is typically on time for her appointments. If the therapist is running late, the client will be given their full appointment length, unless the client is unable to stay for that length of time. If the client is late, the appointment will end at the regularly scheduled time. If the client is more than 15 minutes late and they have notified the therapist, therapist will consider the appointment as a no-show and the client will be billed accordingly.

Fee Schedule:

50 minute session	\$175
80 minute Session	\$300
Couple's Weekend Intensive	\$3000
Reports/Letters	Billed for therapist time

Phone Calls: Clients are free to call at any time. I check my messages frequently during regular business hours, Tuesday through Friday, 10am to 7pm. I will always return your call/text as soon as possible. Psychological emergencies do occur from time to time and you are encouraged to arrange for special appointments at those times. However, if you even have an emergency and I am not immediately available, please call 988 or 911 or go to your local emergency room. Therapist will bill clients for phone calls when phone calls are in excess of five minutes.

Billing/Collections: Therapist will bill insurance companies she is in-network with. . Payment for deductibles, copays and private pay clients is due at the time of services. Clients not making

payments on their account will be turned over to a collection agency and will be charged for the cost of collection, finance charges and any related fees necessary. A 10% per month finance charge will be added to any late account.

I hereby certify that I have read and received a copy of these policies and procedures of therapist, Catherine M Melo, MSW, LCSW.

This signature also serves as a release to give information to insurance company concerning diagnosis and treatment progress.

Signature_____Date_____

Signature_____Date_____

Catherine M Melo, MSW, LCSW
Licensed Clinical Social Worker
4001 Main St., Ste 313
Vancouver, WA 98663
P: 503-360-4909

Consent for Treatment

Catherine M Melo, MSW, LCSW, has my consent to assess my psychological/emotional condition, make a diagnosis, formulate a treatment plan and render therapy as needed to achieve the mutually agreed upon goals of treatment.

Outpatient psychotherapy may include diagnostic services, crisis intervention, individual, group, marital or family therapy. Psychotherapy consists of face to face contacts between the persons involved in therapy and the therapist, Catherine M Melo, MSW, LCSW. The focus is on the presenting problem and associated feelings, assessing possible causes of the problem, previous attempts to cope with it and possible alternative courses of action and their consequences.

The frequency and type of treatment will be decided between me and my therapist, Catherine M Melo, MSW, LCSW. . The therapeutic alternatives will be discussed with me and I will be asked during the course of my treatment to give verbal consent for various psychotherapeutic services.

The expectation is that I will benefit from psychotherapy but there are no guarantees that this will occur. It is my understanding that outpatient psychotherapy does not have significant risks to me. Maximum benefits will occur with regular attendance at my scheduled therapy sessions It has been explained to me that I may feel conflicted at times about my therapy as the process has the potential to be uncomfortable. I also understand that I have the right to terminate treatment at any time.

Client Signature_____Date_____

Client Signature_____Date_____

Catherine M Melo, MSW, LCSW
Licensed Clinical Social Worker
4001 Main St., Ste 313
Vancouver, WA 98663
P: 503-360-4909

**Declaration of Agreement Regarding
Missed or Canceled Appointments**

I understand and agree to the following:

It is my responsibility to notify Catherine M Melo, MSW, LCSW

Phone Number: **(503) 360-4909**

24 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

I agree that I will be billed the full contracted rate for clients using insurance and the full rate for private pay clients in the event that I miss an appointment or fail to cancel 24 hours prior to the scheduled appointment. I understand that not making personal payments on my account will result in the account being turned over to a collection agency and I will be charged the cost of the collection, finance charges and any related fees necessary.

Client _____ Date _____

Client _____ Date _____