Tricia Andor, MA, LPC
Landscapes Counseling & Psychotherapy
401 E. 8th St., Suite #200-H
Sioux Falls, SD 57103
(605) 695-7913

Thank you for choosing Tricia Andor, MA, LPC for your counseling. Your first appointment will last 75-80 minutes. We realize that starting counseling is a big decision, and that you may have many questions. This document is intended to inform you of policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you the information you need.

Authorizations & Policies

AUTHORIZATION FOR CARE & TREATMENT:
I voluntarily request the therapy services of Tricia Andor, Landscapes Counseling & Psychotherapy for the client whose name appears below. I understand that I may question or refuse any procedures or methods at any time. In requesting these services, I am aware of the following rights and agree to the following responsibilities.

CONFIDENTIALITY STATEMENT:
I understand that information about my assessment or treatment will not be released to anyone without my written permission, unless required by law. In some circumstances, the law may require that mental health professionals report to appropriate authorities certain situations, but not limited to: when a person is a danger to themselves or others, including intent to harm self or others, suspicion of child/elder abuse/neglect and when court ordered. I understand that in legal cases, my treating mental health professional or my records may be subpoenaed against my will by the court and if I disagree I should seek the advice of my personal attorney.

PSYCHOLOGICAL SERVICES & POSSIBLE RISKS:
I understand that participation in therapy can result in a number of benefits, including improving interpersonal relationships and resolving the concerns that have led me to seek therapy. I also recognize that working toward these benefits requires effort, involvement, honesty, and openness on my part. I recognize that there are some risks to counseling as well. These risks may include the experience of intense, unwanted, uncomfortable feelings, recalling unpleasant life events, facing unpleasant thoughts and beliefs, or increased awareness of such. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can result in

your feeling angry, depressed, challenged, disappointed, or anxious. In counseling, major life decisions are sometimes made, such as making changes in behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member can be viewed negatively by another family member. Change will sometimes be swift and easy, but other times will be slow and frustrating. I understand that there is no guarantee that counseling will yield positive or intended results.

TERMINATION & REFERRAL:
I also understand that Tricia Andor, LPC, or I have the right to discontinue my treatment at any time and that I will be provided with a referral if clinically appropriate, or if requested by me. Services may also be terminated or delayed for non-payment. My file will be automatically closed for clinical purposes if there is no face-to-face contact for longer than 2 weeks from the last attended appt.

TYPE OF CARE:
I am aware that Tricia Andor is not a forensic evaluator.

INSURANCE AND FEES:
I understand that payment in cash or check made out to Tricia Andor is expected at the time of my visit.

As a courtesy, Tricia Andor, LPC contracted with Maximum Medical Billing, will process my insurance if information is provided, and provided she is a provider for my particular health insurance company. I understand that I am financially responsible to Tricia Andor for all charges including those not covered by my insurance, as well as penalties for failure to pre-certify. There may be additional charges for collateral contacts. I have been informed of fees and authorize insurance or other payment directly to Tricia Andor of Landscapes Counseling & Psychotherapy.

If I have not paid my account balance for more than 60 days, I understand that Tricia Andor, LPC has the option of using legal means to secure the payment. This may involve hiring a collections agency or going through small claims court which require disclosure of otherwise confidential information (in most situations, this is only demographic information, the nature of the services, and the amount due).

AUTHORIZATION FOR INSURANCE TO PAY BENEFITS TO TRICIA ANDOR, LPC *(If utilizing insurance for payment)*:
I authorize Tricia Andor to release information necessary to process my insurance claim, and authorize insurance payment of benefits to Tricia Andor, LPC. I authorize release of clinical information to third party payers and/or their reviewing contractors to comply with pre-certification, continued services and retrospective review, reimbursement or for accreditation surveys.

I acknowledge that my signature on this document authorizes Tricia Andor to submit claims for benefits, for services rendered, without obtaining my signature for each and every claim to be submitted. I am bound by this signature as though I had personally signed the particular claim.

_____

Signature Print Date

CANCELLATION & NO SHOW POLICY:
Keeping regular appointments is an important part of an effective treatment plan. I understand that there is a full charge for cancelled/missed sessions with less than 24-hour notice (unless both client and therapist agree that missed session was because of unforeseeable circumstances).

CONTACT/COMMUNICATION AND REMINDERS:
I will utilize telephone contact and voicemail (not email or text) to communicate about any changes I need to make regarding my appointment. I understand that the use of the internet/email are not secure and are not considered confidential forms of communication. By checking the "yes" blank below I hereby waive confidentiality and give consent to communicate by internet/email.

_____ No ____ Yes Email address: _____

If I initiate communication by text or email, that action itself will serve as consent and waiver of confidentiality.

RECEIPT OF PRIVACY PRACTICES: I have been provided with a complete HIPPA document (Notice of Privacy Practices). I fully understand and accept the terms of this practice.

I have read the above and completely understand my rights and responsibilities. I have been given the opportunity to ask questions which have been answered to my satisfaction.

_____

Client Signature Print Date

_____

Therapist/Witness Signature Print Date