Northern Wellness Counseling, LLC
Nathalia Grauvogel MS, LPC
701 Sesame St, Suite 201, Anchorage, AK 99503 • 907-227-0029

Demographic Information

(If you are completing this for your minor child please use their information.)

Client's name: _____ Date: _____

Form completed by (legal guardian): _____

Date of birth: _____ Age: _____ Gender: Female Male

Physical Address: _____ City/Zip:_____

Mailing Address: _____City/Zip:_____

Client Phone Number:_____ Mobile Home Work

Legal guardian phone number:_____ Mobile Home Work

Email Address:_____

Legal guardian email address:_____

How were you referred? _____

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Insurance Information

Policy Holder Name (please print):_____Date_____

Gender: M F Policy Holder Date of birth: _____ Age: _____

Primary address: _____

_____

Guarantor (client or guardian, if client is a minor):

_____

Employer: _____ Occupation: _____

Health Insurance Company: _____

Address: _____

Phone number: _____

Identification number: _____ Group number: _____

By signing the two following bolded statements, I authorize Northern Wellness Counseling, LLC to bill my insurance company using SIGNATURE ON FILE (SOF) as the authorizing signature.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Policy Holder Printed Name: _____

Policy Holder Signature: _____

Date:_____

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Service Contract and Disclosure Statement

This document contains important information about my professional services and business practices. Please read it carefully and write down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

Counseling Services:

I am a Master level counselor with a graduate degree in counseling psychology from Alaska Pacific University with training and experience diagnosing and treating a variety of emotional and psychological problems. I have experience working with adolescents doing individual and family therapy, adults doing individual, couple, group and family therapy. I help clients overcome the following issues: transitional or major life changes, grief and loss, addiction issues, mood and anxiety disorders, trauma and dissociation, managing stress and emotions, attachment issues, personality disorders and somatic issues. I also have experience working with opioid addiction in an opioid maintenance (Suboxone) program. I use an eclectic and person centered approach to address these issues but I am trained in the following modalities: CBT (cognitive behavioral therapy), EMDR (eye movement desensitization therapy), EFT (emotional freedom technique), IFS (Internal Family System therapy), Hypnosis (level 1 and level 2) and Sensorimotor Psychotherapy (level 1 and 2), and Brainspotting (level 1 and 2). I continually participate in on-going trainings and consultation groups for the above modalities as well as other areas of clinical interest to ensure that I am facilitating your treatment with the latest research and evidenced based practices.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant areas in your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who participate in it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are however no guarantees for a particular outcome even if you attend sessions on a weekly basis. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and most importantly outside of sessions.

Financial Policy:

My office will bill all primary insurance claims electronically. In-network insurance holders will be responsible for any co-pays at the time of service. Out-of-network insurance billing may be processed by this office, but clients are responsible to pay for the full session fee at the time of service. Additionally, out-of-network insurance payments will be sent directly to clients and not to this office. Regardless of how someone choses to pay **I require clients to authorize me to keep their credit card information on file for agreed upon transactions.** If for some reason a client gets behind payment more than 60 days and arrangements for payment have not been made, then I may use legal means such as a collection agency or small claims court to secure payment. Personal information such as name, services provided, and amount due could be released. Note: I prefer to work through these issues together than use legal means to secure payment.

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Professional Fees:

60-minute intake session…… $300.00

55-minute individual psychotherapy session……. $250.00

45-minute individual psychotherapy session……. $230.00

Cash, checks and credit cards are accepted forms of payment.

There will be a $25.00 charge for all checks returned for non-sufficient funds.

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or a summary of your visits can be prepared for you instead. Fees for documentation such as copies of records are $50.00. For letters and/or reports I charge my hourly rate of $250.00 for the time it takes to complete your requested task. Please allow 1 – 2 weeks for your records to be prepared. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that we review them together so that we can discuss the contents; or I can send them to another mental health professional who is working with you.

Communication Policy:

Email and texts will not be used for primary communication between the therapist and client. I do not do therapy by email or text message, since there is too much information I am unable to see or hear. If you prefer you may contact me via text message or email ONLY in regards to rescheduling, pending appointments, or if you are running late. **Note: email and text messaging are not a secure form of communication and because of the nature of the internet, I cannot guarantee your confidentiality if you choose to use this method.**

Client Responsibilities:

Clients are responsible for attending sessions as scheduled.
Therapy sessions are by appointment only and because your appointment time is reserved only for you, it is necessary to charge for appointments that are not canceled 24 hours in advance as I can often fill these appointments with notice. If you're able to reschedule for later that week or I am able to fill your canceled slot then you will not be charged the $100 cancelation fee. **Note: insurance does not pay for missed appointments. The fee charged for missed appointment is $150. Exception is made if you are unable to attend your appointment due to illness, weather, school closures, work conflict, or jury duty.** Please contact me at 907-227-0029 or email nothernwellnessak@gmail.com; if I do not answer, leave a message stating you will be unable to attend the scheduled session. If you miss or cancel three sessions in a row you will be

discharged from services due to non-participation.

Clients are responsible for their well-being.
Due to the nature of my business, I am often not immediately available by telephone and therefore, unable to provide immediate crisis intervention. You are responsible for using your own crisis plan between appointments and during times I cannot be reached by telephone. If you do not have a crisis plan, I will assist you to develop one. **If you are experiencing an emergency or are in crisis, call the 24-hour Crisis Emergency Hot-line at (907) 563-3200, call 911 or go to our nearest hospital emergency room as they are prepared to handle psychiatric emergencies.**

Causes for Discharge:
If a client threatens or reports that they plan to threaten myself, one of my family members or anyone in my office this will be cause for immediate discharge from my practice.

If a client misses or cancels three sessions in a row, they will be discharged from services due to non-participation.

If I find that our therapeutic relationship is not benefiting you and/or we both find that it is no longer beneficial then I will give you recommendations and list of referrals to find another therapist.

Services for Minors:

If you are under eighteen years of age, please be aware that the law provides your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else, have been assaulted, or are engaging in illegal activity which includes drug use. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, one or more family members in treatment sessions. A schedule for such sessions may be determined following the initial evaluation session or be set up on an "as needed" basis. In cases where client's parents are divorced, both parental signatures are needed on all forms. Additionally, both parents will be cc'd on all email correspondence.

Therapist Responsibilities:

Protecting client confidentiality
I am required by law and ethical principles to protect your confidentiality. You may authorize me to release oral or written information regarding your care with others by signing a Release of Information form however there are a few exceptions which are as follows:

1. The law requires that I notify others if I judge that a client has made a clear threat of violence to an identifiable victim.
2. If I access that client is highly suicidal or unable to take care of themselves, I may notify proper authorities to arrange for hospitalization.
3. I am obligated by law to report suspected physical or sexual abuse or severe neglect of children, elderly or the handicapped.

4. In cases of criminal liability or child custody disputes, my records may be subpoenaed by a legitimate court of law. *
5. When insurance reviewers request information about your therapeutic progress, I will release information only as requested. *
6. I may release your name for bill collections processing. No treatment related content will accompany this disclosure. Since payment usually occurs at each session, this is very rare.
7. To provide my clients the best standard of care I periodically seek consultation and clinical direction from other professionals if this occurs, your confidentiality will be maintained and your name and identify will be disclosed only in compliance with AS 08.29.200. The consultants are also bound to keep the information confidential. If your case is discussed at consultation, a note will be placed in your clinical record.

*I will do my best to protect your confidentiality within the limits of the law. If you foresee any possible legal issues, such as divorce or custody battles, please inform me. I am not trained in the legal profession; I do not do forensic or parental evaluations and I prefer to not testify and/or appear in court. If I am called to court for any reason by a person/court in regard to your care, you are responsible for paying for my time and will be charged $2,000 for the court date and then my hourly rate if I am called to appear again thereafter.

* You should also be aware that most insurance companies require a clinical diagnosis to authorize services for reimbursement. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). Any requested information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

Some of the information provided in this document is required by the Board of Professional Counselors which regulates all licensed professional counselors.

Board of Professional Counselors
Division of Corporations, Business & Professional Licensing
P.O. Box 110806
Juneau, AK 99811-0806
Phone: (907) 465-2551

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Agreement and Consent for treatment

My signature below acknowledges that I have read and received a copy of the above material (counseling services, meetings, professional fees, payment and insurance reimbursement, contacting me, professional records, services for minors and confidentiality). I hereby consent to abide by the terms outlined above. I understand that I am responsible for all fees at the time of service unless other arrangements have been made in advance and know that I am free to ask questions at any time for clarification. I consent to treatment by Nathalia Grauvogel, LPC

Client Printed Name and Signature Date

Legal Guardian Printed Name and Signature Date

Legal Guardian Printed Name and Signature Date

Nathalia Grauvogel, MS, LPC Date

My initials below acknowledge that I have read, understood, and received the following:

_____Notice of Policies and Practices (HIPPA) Date_____

_____Service Contract and Disclosure Statement Date_____

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PATIENT RECORD OF COMMUNICATION AND DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). (See HIPAA policy)

In the event in which Nathalia Grauvogel, LPC must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say my name or the nature of the call, but rather my first name or first and last name only.

If this information is not provided to me (below), I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, I will say that it is a personal call. I will not identify the clinic (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

I wish to be contacted in the following manner (check all that apply):

□ Home Phone_____
- □ OK to leave message w/detailed information
- □ Leave message w/call-back number only

□ Written Communication
- □ OK to mail to my home
- □ OK to mail to work/office

□ Work Phone:_____
- □ OK to leave message w/detailed information
- □ Leave message w/call-back number only

□ Fax_____
- □ OK to fax to this number

□ Cell Phone: _____
- □ OK to leave message w/detailed information
- □ Leave message w/call-back number only
- □ OK to correspond via **text ***

□ **Email*:** _____
- □ OK to correspond via this email address*
- □ OK for billing to use this email address*

***Note:** For all electronic means of communication this is a non-secure means of communication due to possible third-party access and not HIPAA compliant.

My signature below acknowledges the fact that I have read the material and am informed about the above Alaska mental health laws, and the practices of this office. I understand the meaning and ramifications of the law, and know that I am free to ask questions at any time for clarification.

_____

Printed Name and Signature Date

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting Nathalia Grauvogel, LPC. This authorization will remain in effect until cancelled. **Please note** that the cancelation fee (if it applies) will be charged to this card on the date the services were supposed to be rendered.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Card CVV # (3-digit code on back of card):_____

Cardholder ZIP Code (from credit card billing address):_____

I, _____, authorize Northern Wellness Counseling, LLC to charge my credit card above for agreed upon services and (if applicable) the cancelation fee. I understand that my information will be saved to file for future transactions on my account.

Cardholder Signature:_____ Date:_____