WELCOME

Case No#_____

The purpose of Family Counseling and Children's Services of Lenawee County is to help you with personal, marital or family issues/problems. Our staff members are professionally trained social workers, psychologists, and psychiatrists.

The content of all interviews will be held in strictest confidence by all agency personnel. You must sign a release if you wish to have the agency talk to or send a report to someone else. Current law allows information about you to be released if you pose a danger to yourself or others and requires the reporting of suspected child abuse or neglect.

As an agency, we have the right to expect that our clients will conduct themselves in a manner, which does not pose a danger to themselves or to others. Dangerous or unpleasant behavior or substance abuse may result in a request to leave the agency. Both staff and clients are expected to use courtesy in their relationship.

Family Counseling and Children's Services of Lenawee County is a private, non-profit, non-sectarian counseling agency serving any resident of Lenawee County on an ability to pay basis. No one will be denied service bases on age, race, color, religion, sex or handicap.

The following fees will be charged for the following services:

A letter requiring a therapist signature - $25.00
A written report -$50.00
A court appearance - $75.00/hr. of testimony and $37.50/hr. for court time.

Policy for making copies:

$1.18 for pages 1-20
$0.59 for pages 21-50
$0.24 for pages 51-up

Please refer to the financial policy regarding other fees.

I understand that fees are to be paid at the time of the appointment unless arrangements have been made. If my insurance company does not cover any fees or any portion of fees for the services my dependent or I have received, I accept responsibility for them. If maximum insurance benefits have been reached, I will be responsible for any fees for services subsequently rendered.

I agree to provide information for the development of the treatment plan to be used and that I will keep all scheduled appointments. I accept that I am financially responsible for all scheduled appointments and am aware that any appointment that is missed without my giving 24 hours notice may be billed directly to me because insurance companies will not pay for missed appointments. Payment for a missed or late cancelled appointment is due within two weeks of the appointment. If treatment or diagnostic evaluation is terminated

by my choice, or because of a violation of program rules, I agree to pay all outstanding fees existing at the time of termination.

I agree to inform Family Counseling and Children's Services of any changes in my insurance benefits and assign insurance benefits, if applicable, to Family Counseling and Children's Service. I understand that accounts more than 90 days overdue where insurance payments are not made directly to Family Counseling and Children's Services may be subject to collection.

I recognize that if my dependent or I have been ordered by a court to seek treatment or diagnostic services at Family Counseling and Children's Services, that court will require one or more reports. My written consent will be requested for this to occur. I do understand that Family counseling and Children's Services shall not be obligated to send any report concerning me or my dependent to any one until the balance on my account is paid in full.

_____Yes _____No I agree to be contacted by phone.
_____Yes _____No I will allow messages to be left with family/household members.
_____Yes _____No I will allow messages to be left on an answering machine or voice mail.
_____Yes _____No You may contact me at work, the phone number is_____.

_____Yes _____No You may contact _____
Name Relationship

_____
Address Phone Number
for the specific purpose of a medical emergency, which may include physical or mental health. (Valid only for the period of time that you are receiving services from Family Counseling and Children's Services.)

I have read the information, have received copies of this information and agree with the aforementioned policies of Family Counseling and Children's Services.

_____ _____
Signature of Client (or Parent/Guardian) Date

_____ _____
Witness Date