Carolina Forest Counseling

Jane Fortune, LPC
Owner
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4999 Carolina Forest Blvd Ext
Myrtle Beach, SC 29579

Amy Gurd
Office/Accounts Manager
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Welcome to my practice. I am pleased to have the opportunity to serve you and hope that this handout will provide helpful information in making an informed decision concerning my services.

Please ask questions at any time.

Organizational Information

Hours and Location of Operation: My office is located at1409 Hwy 301N and Carolina Forest Crossings Shopping Center, 4999 Carolina Forest Blvd Ext, Myrtle Beach, SC. Telephone calls from 10:00 a.m. until 5:00 p.m. may be answered with voice mail, and responded to as soon as possible. If there is a life or death emergency please call 911.
Appointments are scheduled 10:00 am to 5:30 pm, Monday through Thursday; Friday 10:00 am to 4:00 pm, and Saturdays, when available.

Background & Training: I have a Bachelor's Degree in Psychology, and Master's in Professional Counseling from Liberty University. I am licensed as a professional counselor in South Carolina, North Carolina, and Virginia. I have had experience in treating a wide variety of individuals including children, adolescents and adults; individual, couples, and family.

Primary Specialty Areas of Expertise

Philosophy: I accept in my practice clients whom I believe have the capacity to resolve their own problems with my assistance. The foundation of the healing process is the therapeutic relationship which is based on trust, respect, honesty, confidentiality and effort of both the therapist and Client. As people learn more about their strengths and weaknesses, they usually become more accepting of themselves and others and feel more empowered to accomplish their goals. As the client, you are responsible for setting the goals you want to accomplish and can terminate counseling at any time. My responsibility is to help you accomplish these goals in the shortest time possible. If counseling is successful, you should feel better about yourself and be able to face life's challenges in the future without my support or intervention. I cannot guarantee results.

Confidentiality: What clients share in sessions is held in confidence between the therapist and the client. Permission to share with anybody is done with client's written permission unless client indicates a threat of harm to self or others.

I ask that you be as honest and as open as possible in discussing your concerns. If you are unclear about anything regarding your therapy, please ask questions. Psychotherapy can be very helpful for some individuals but it is not without some risks. These risks may include the experience of intense and unwanted feelings, such as sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs or possible alteration of an individual's relationships. I will make every effort to minimize potential risks and hazards which are not helpful to the therapeutic process. Often in therapy, major life decisions are made, including: decisions involving families or friends, changes in relationships, or changes in your jobs or careers. These decisions are a legitimate outcome of therapy as a result of an individual's calling into question some of their beliefs and values, recognizing their strengths, increasing their self-acceptance, alleviating symptoms and problems or learning more helpful coping skills. I use research-based "best practices therapy methods" including, but not limited to, Cognitive-Behavioral-Emotive Therapy (CBET), Solution-Focused Brief Therapy, Empathetic Therapy, faith based counseling, Person Centered Therapy, Strategic or System, and Family Systems Therapy, based approaches, assessments, and bibliotherapy. These methods sometimes utilize psycho-education methods with homework assignments.

Billing/Financial Policies

Fees, Payments and Insurance: I will make every effort to keep down the cost of your medical care. Therefore, I require that you pay for your treatment at the time of your visit. The cost of therapy is $160.00 for the initial session, which usually last 75 minutes including time to complete paperwork. Regular session rates are as follows: $135.00 for each 60 minute session, any session that lasts more than an hour will be charged a $45 rate for each additional 15 minutes. Please be aware that not all insurance will pay for more than an hour of counseling, if the insurance does not cover this it will become your responsibility to pay that part of the fees. Payment may be made by cash or check. If you have insurance coverage I ask that you make your co-pay, co-insurance and unmet deductible fees at the time of your office visit. If at any time during your treatment you are having financial difficulties and cannot make the required payments on your account, please make me aware outside of our therapy session to set up financial arrangements or you may call Amy Gurd, Accounts Manager. Most plans include co-payments/co-insurance, a deductible and other expenses which must be paid by the patient. If you have insurance, please bring your insurance card with you. I will automatically file your insurance for you if you have provided us with the necessary information. **However, I cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services rendered, you will ultimately be responsible for payment.** If you have a change in insurance coverage or benefits, please notify me immediately. For patients without insurance, fees will be the basic fee, or depending on the circumstances, based on a sliding scale and will need to be paid prior to each session

Cancellations and no shows: Since therapists see patients by appointment only, and each appointment constitutes a significant portion of the therapist's day, it is common practice to charge a fee for missed appointments. A charge of $55.00 will be made if you do not show up for an appointment. If this is to occur again, a charge of $65.00 will be assessed. The third time you do not show up for an appointment our office will no longer see you. These charges are not reimbursable by insurance carriers. These charges must be paid before the next session unless other arrangements have been made by our office. I would appreciate you notifying me at (843) 506-0462 or (843) 268-4980 if you will not be attending a session with as much notice as possible-preferably 48 hours or more. If you do not reach me personally, please leave a message on my voice mail of your cancellation.

Returned Checks: If you pay for any service provided with a check and that transaction is returned to me from your bank as nonpayable, there will be a charge of $35.00. After a non-payment incident, checks may no longer be accepted and you will be required to pay all outstanding balances on a **cash only basis**.

Psychological Testing: Psychological testing is sometimes a critical component of evaluating problems and strengths and assisting clients in accomplishing their goals in the shortest time possible. After an initial interview I may recommend such assessment. Costs for this service depend on the testing instruments used and the length of time required for administration and scoring. The exact charges will be discussed with you prior to any testing.

Copying Fees for Medical Records: I will attempt to honor your request of medical records as quickly as possible. I make every effort to respond within 30 days. The charge for copying and mailing medical records is as follows:

- Handling and processing fee $40.00 per request
- Photocopying (pages 1 – 25) $ .50 per page
- Photocopying (pages over 25) $ .25 per page

This charge is billed to the organization/individual requesting the records as outlined in your authorization and **payment is due in advance of the records being released**. However, you will ultimately be responsible for any unpaid fees should that party not make payment.

Requests for Letters: Therapists take a great deal of time corresponding with requested individuals on the behalf of their patient. There is a charge for letters written at the request of the patient. If a legal letter is needed, a fee ranging from $50.00 to $200.00 will be charged. The charge will vary and is based on the clinical and clerical time required to complete the letter. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a letter can be delivered.

Request for Forms: In most instances, I will complete health or treatment forms on your behalf. However, please be aware that there is a charge of $15.00 for forms to be completed at the request of the patient. In the event that the form is lengthy or complex, I may request that you schedule an appointment and complete the form as part of your session. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a form can be delivered.

Telephone Consultations: There is usually no charge for a brief phone conversation with your provider. If you require a more lengthy discussion, I will schedule a time with you by phone. The fee for phone consultations will be $15 per a 15 minute period. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost.

Court Appearances: Therapists are occasionally needed to testify in court or provide a deposition as an expert witness for a patient regarding a legal matter. If you think you may be involved in a legal dispute or may require a professional testimony, please inform me as quickly as possible. If a judge or another party subpoenas me or your medical records, I am legally required to comply. If you or your attorney subpoenas me to appear in court on your or your dependent's behalf, **you will be charged a prepayment fee of $180.00 to reserve my time. Full payment is expected to be paid prior to the scheduled court date**. I have to rearrange my scheduled patients in order to appear in court for you, if pre-payment is not made **in advance** I **will not** attend. If the time required in court is in excess of two hours (2) hours (including travel time) you will be charged an additional 90.00 per hour. You will be billed for the balance due. You will

be charged for my presence in court, regardless if I testify or not. If court is cancelled my office needs at least a 24 hour notice in order for you to receive reimbursement of your initial $180.00 fee. Insurance will not reimburse for these fees.

Payment of Outstanding Balances: Each month I mail billing statements for each account with outstanding balances due. **You are responsible for paying the total amount due upon receipt of the statement.**

• If I do not receive payment in full for balances due within 30 days of billing, this may result in the suspension of services.
• Outstanding balances exceeding 120 days past due will result in collection procedure. In the event that your account is forwarded to an external collection agency, all collection fees will be added to your account. In addition, finance charges of 10% will be added each month to accounts which are 90 days past due.

Office Policies

Messages: As you will notice, I do not accept phone calls while with you. During those times and at other times during the day or evening, I will have voice mail available. Messages are checked during the day, and I will attempt to call you back as soon as possible. Usually, I can get back with you within 24 hours. If you need to speak to me directly during regular office hours, please leave your name and phone number on my voice mail. On evenings, weekends, and holidays, the messages will be received and acted upon during the next working day.

Complaints: If at any time you are dissatisfied with my services, please let me know. If you are still not satisfied you may contact the South Carolina Department of Health Professions at (803) 896-4470. I am required to follow a Code of Ethics. If you would like to see a copy of the Code it can be found on-line at the website for the American Counseling Association at www.counseling.org.

Counseling and Financial Records: Counseling and financial records are maintained on each client for a period of 10 years for adults and 13 years for children and adolescents. Records are stored in boxed paper files in a secure central location. The records are my property but may be reviewed by a client with 30 days notice.

Noncompliance: A therapist may cancel or terminate services for noncompliance with the plan of care, failure to keep or cancel appointments, violent behavior, or a threat of violence or involvement in criminal behavior.

Consultation: In keeping with generally accepted standards of practice, I may confidentially consult with other mental health professionals regarding the management of treatment. The purpose of the consultation is to assure quality care. Every effort is made to protect the identity of the clients.

Counseling Students: In order to earn licensure as a professional counselor, counseling students must do counseling while in school and upon graduation with proper supervision. Students in this office will be carefully supervised and may see individuals on a self-pay or pro bono basis.

Emergencies: My office is not set up to routinely provide crisis intervention services. In case of an emergency and/or my office is closed, you may go to your local Emergency Room and talk to a crisis counselor.

Permission to Treat a Minor Child: Please note that I require written permission before I can treat any client under the age of 18:
• When parents are married, the signature of one parent is sufficient to provide treatment.
• If the parents are divorced, I require the signature of the parent having legal custody of the child.
• If the parents have joint legal custody, I may require the signature of both parents
• If the parents are separated, I may also require the signature of both parents to provide treatment.
Phone authorizations are not accepted. Parents must sign the "Informed Consent/Permission to Treat Form" in person or have it notarized with seal and signature if signed off premises. I will not provide treatment for any child who does not have the proper signed consent form(s) on file.

Emergencies at the Facility: In case of a medical emergency at my facility, I will contact the nearest and most appropriate medical facility to provide care.

I hope this brief introduction answers some of your questions. Please feel free to ask any additional questions you may have. Again, I welcome you and trust that our relationship will be mutually beneficial.

Revised 9/6/17

I have been given, read and fully understand the "Welcome to My Practice" packet. I do not have any questions for Jane Fortune, LLC or they have all been answered. I authorize consent for treatment of outpatient therapy by Jane Fortune, LPC to me or my dependents.

Please initial the following blanks:

_____I agree to be responsible for payment of all services rendered on my behalf and/or my dependents.

_____ I understand that my insurance carrier may pay less than the actual bill for services. I understand that verification of benefits does not guarantee payment. I also authorize payment of any medical benefits to be made directly to Jane Fortune, LPC, otherwise payable to me.

_____I authorize release of information/assignment of benefits, and the release of any medical or other information necessary to process claims to the third party payers. (Commercial Insurance, Medicare, Medicaid, SOVA, and Health Maintenance Organizations)

_____I have been provided information as to my rights that I believe I understand them, and if I feel my rights are being violated I may contact South Carolina Professional Licensing Board, the number of which has been provided in the "Welcome to my Practice" Handout.

_____I also acknowledge I received the privacy health information act of April 13, 2003 pertaining to the office of Jane Fortune, LPC.

SIGNATURE _____ DATE _____

Witness _____Date _____

Please initial below stating you are fully aware of the following policies and agree to stay in communication with our office as long as you are an active client.

_____**Fees, Payments and Insurance:** I will make every effort to keep down the cost of your medical care. Therefore, I require that you pay for your treatment at the time of your visit. The cost of therapy is $160.00 for the initial session, which usually last 75 minutes including time to complete paperwork. Regular session rates are as follows: $135.00 for each 60 minute session, any session that lasts more than an hour will be charged a $45 rate for each additional 15 minutes. Please be aware that not all insurance will pay for more than an hour of counseling, if the insurance does not cover this it will become your responsibility to pay that part of the fees. Payment may be made by cash or check. If you have insurance coverage I ask that you make your co-pay, co-insurance and unmet deductible fees at the time of your office visit. If at any time during your treatment you are having financial difficulties and cannot make the required payments on your account, please make me aware outside of our therapy session to set up financial arrangements or you may call Amy Gurd, Accounts Manager. Most plans include co-payments/co-insurance, a deductible and other expenses which must be paid by the patient. If you have insurance, please bring your insurance card with you. I will automatically file your insurance for you if you have provided us with the necessary information. **However, I cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services rendered, you will ultimately be responsible for payment.** If you have a change in insurance coverage or benefits, please notify me immediately. For patients without insurance, fees will be the basic fee, or depending on the circumstances, based on a sliding scale and will need to be paid prior to each session

_____**Returned Checks:** If you pay for any service provided with a check and that transaction is returned to me from your bank as nonpayable, there will be a charge of $35.00. After a non-payment incident, checks may no longer be accepted and you will be required to pay all outstanding balances on a **cash only basis**.

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Revised 9/6/17

Contact Information

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TODAY'S DATE_____

__PATIENT'S INFORMATION (required-please fill out completely):__**

_____ _____

Last Name First Name Middle Initial Responsible Party (If Minor)

MAILING ADDRESS (STREET AND/OR PO BOX)_____APT.#_____

CITY_____STATE_____ZIPCODE_____

SEX: ____MALE ___FEMALE DATE OF BIRTH_____ AGE_____ SOCIAL SECURITY NUMBER_____

___SINGLE ____MARRIED ____DIVORCED_____WIDOWED ____SEPARATED FAMILY PHYSICIAN_____

PATIENT EMPLOYER/SCHOOL_____ OCCUPATION/GRADE LEVEL_____

ADDRESS_____ CITY_____STATE_____ZIP_____

IN CASE OF EMERGENCY, PLEASE NOTIFY THE FOLLOWING_____PHONE _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

__SPOUSE/PARENT INFORMATION__:

Name _____ Employer _____

ADDRESS_____CITY_____ STATE_____ ZIP_____

OCCUPATION_____ SOCIAL SECURITY NUMBER_____

__COMMUNICATION BETWEEN YOU AND YOUR THERAPIST__

OCCASIONAL IT WILL BE NECCASARY FOR OUR OFFICE TO CONTACT YOU REGUARDING APPOINTMENT OR OTHER MATTES ABOUT COUNSELING. THIS PERMISSION FORM WILL HELP ME KNOW WHEN AND HOW TO CONTACT YOU IN WAYS WHICH ARE COMFORTABLE FOR YOU.

BY GIVING PERMISSION FOR ME TO CONTACT YOU IN ONE OR MORE OF THE WAYS LISTED BELOW, YOU ARE AGREEING FOR ME OR MY STAFF TO LEAVE MESSAGES AND INFORMATION. WE WILL ALWAYS TRY TO BE DISCRETE IN ANY MESSAGES I LEAVE, BUT CAN NOT GUARANTEE CONFIDNTIALITY ONE THE MESSAGE IS LEFT.

**EMAIL _____@_____

**HOME:
MAY I CONTACT YOU AT YOUR HOME TELEPHONE NUMBER? IF YES, HOME NUMBER _____ MAY WE LEAVE A MESSAGE? _____

**CELL PHONE:
MAY I CONTACT YOU AT YOUR CELL PHONE NUMBER? IF YES, CELL PHONE NUMBER _____ MAY WE LEAVE A MESSAGE? _____

__INSURANCE INFORMATION (required-please fill out completely)__**

PRIMARY INSURANCE COMPANY_____PHONE NUMBER_____

SUBSCRIBER'S IDENTIFICATION NUMBER_____GROUP NUMBER_____

SUBSCRIBER'S NAME_____RELATIONSHIP TO PATIENT_____

MH/SB OR CUSTOMER SERVICE PHONE NUMBER ON CARD _____

SPOUSE/PARENT _____ EMPLOYER_____WORK PHONE_____

ALL INFORMATION CONTAINED WITHIN THIS FORM IS BOTH TRUE AND ACCURATE. PLEASE SIGN BELOW:
SIGNATURE OF PARENT OR GUARDIAN AND/OR PATIENT _____**DATE**_____