LINVILLE
COUNSELING SERVICES
A SAFE PLACE TO GROW

FACE SHEET

CONTACT INFORMATION: *Please help us assist you by completing this form.*

Full Name of client	Sex ___ Male __ Female
Street Address	City
State	Zip code
Do you attend Madison Park Church of God?	

In case of a scheduling conflict, please provide us with the following information:

Daytime phone: ( ) -
May we leave a message if you are not available? ___ Yes ____No

Evening phone: ( ) -
May we leave a message if you are not available? ___ Yes ____ No

Email Address:
We will email receipts to this address. If you do not provide an email address and will need your printed receipts, then you will need to put in a request with the scheduler at 765-639-6192. Once requested, receipts are printed when that payment is batched and can be mailed to you or given to your therapist to give to you at your next appointment.****We will not sell or give your email address to anyone: agency, company, church, organization or individual without your written consent.***

Which do you prefer for appointment reminders? _____Phone _____ Email

I have read "INTRODUCTION TO COUNSELING SERVICES" and am in agreement to comply with such. Furthermore, I give consent to Linville Counseling Services (LCS) to provide mental health therapy services to me and/or my minor child at the rate of $_____ per hour (50 minute session). Your fee will be $110 per therapy hour, unless you are utilizing the sliding fee scale and have provided your supportive documentation. Please reference the Counseling Fee Schedule form to obtain your rate, if needed. Payment is expected before your appointment. Super Bill receipts will only be issued to clients paying the full session fee. Client must pay the fee, ask for the Super Bill that the client can then file with their insurance company. Sliding Fee Scale rates are for people not accessing insurance.

To the extent to determine liability for payment and to obtain reimbursement, I authorize release of any information regarding services rendered to be used to collect payment for all services rendered, direct to Linville Services (dba Linville Counseling Services).I understand that I am responsible for the fees for all services rendered at the time of service.

I/We agree that in the event of default in payment, reasonable cost of collection, equal to fifty (50) percent of the delinquent balance, and/or reasonable attorney fees may be added to the amount due on the account.

In signing below, I affirm the information given on this form is true and accurate and I have read the above and fully understand the terms thereof:

Signature of Client or Parent/ Guardian:	Date: