Nicole Massari, LMFT CA-94904 –LCPC ID-6692
NPI# 1003190216 Tax ID# 45-3517109
1500 Heritage Park Street Suite 125 Meridian ID 83646
www.nicolecounseling.com ~ 208-866-1822

Payment Contract for Services

Name:_____
Address: _____City: _____State: _____ Zip: _____
Phone: (Home) _____(Cell) _____

Person responsible for payment: _____DOB: ____/_____/_____
Billing Address: _____City: _____State: _____Zip: _____ Phone:_____
Employer: _____ Phone:_____

Disclosure Statement for Professional Services

Fees:

I/we agree to pay Nicole Massari, LMFT, LCPC (provider) at a rate of $95.00 per 50 minute individual session, and $ 130.00 for family/relationship per 80 min session. (Unless otherwise agreed upon).

A fee of $45.00 is charged for missed/cancel appointments where notice is not give before 24hours.

* (Please note that even if you are not intending to pay by credit card, I ask that you fill out the credit card authorization. This authorization remains on file if you no-show for your scheduled appointment or do not give a 24 hour cancelation notice. Your card will be charged for this one-time fee, as stated in my Disclosure Statement.)

Services that may not be covered by insurance such as report writing and/or court proceedings may incur additional charges.

Insurance (co-payment and deductibles)

For clients with insurance, and which Nicole Massari, LMFT, LCPC, is a provider with, will have their insurance billed for mental health benefits. We will attempt to verify benefit amounts with your insurance company. Mental health benefits are ultimately the responsibility of the client. We suggest you confirm the following:

1. Deductible (annual) amount per person $_____ / Max out of pocket $_____
2. Co-payment for counseling services $_____ (due at each session).
3. Is there a policy limit on sessions per year? Annual amount allowed _____.

Please confirm these benefits with your insurance company. The person who is responsible for payment shall make payment on services that are not covered by insurance, including any detectable and all co-payments.
Payments, co-pays and deductible amounts are due at time of service
I hereby certify that I have read and I agree to these terms of service.

Person Responsible for this account: _____ Date: ___/___/___

CREDIT CARD PRE-AUTHORIZATION
For Use by Nicole Massari, LCPC

Please understand that insurance companies do not reimburse for missed appointments. I understand that stuff happens and the first missed appointment is on me but following that I charge a $45.00 fee for missed appointments.

I authorize _____,
(Provider Name)
to keep my signature on file and to charge my account for:
Payment of my session in the amount established by my provider _____
(Amount)

☐ For a No-Show or missed session without a 24 hour cancellation notice.
☐ For Co-pay.
☐ For past due sessions.

I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session or I missed session or did not cancel my appointment with in 24 hours.
I also understand that if I want to use my credit card for my session (s) that I will make a payment at the end of the session I will be attending using the physical credit card.
I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy.

Client's Name: _____
Card Holder's Name: _____
Card Holder's Address: _____
City: _____ State:_____ Zip: _____
Phone: _____ Email: _____
☐ Visa ☐ Master Card ☐ American Express
Card# _____ CSC#_____
(3-digit # on back of card)

Signature:_____ Exp. Date: ____/ ____/ ____

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4696 W. Overland Road #118
Boise, Idaho 83705
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Insurance Information

Primary Insurance Company: _____Policy #: _____Group #: _____
Policy Start Date: _____/_____/_____ Co-Pay: $_____ Referral Required? _____Yes _____ No
Insurance Co. Address: _____ Phone #: ( ) _____
Policyholder: Name _____ Date of Birth: _____/_____/_____
Relationship to client: _____

2nd Insurance Company_____ Policy #: _____ Group #: _____
Policy Start Date: ____/____/____ Co-Pay: $_____ Referral Required?: __Yes __ No
Insurance Co. Address: _____ Phone #: ( ) _____
Policyholder: Name _____ Relationship: _____
Date of Birth: _____/_____/_____

If you are using EAP company benefits, what company provides the EAP services?

Name: _____ Phone #: _____

Does this company require pre-authorization? : (Most require pre-authorization) □ Yes □ No

Did you receive a pre-authorization number? Or letter (List number)_____
If you received a letter please attach a copy

******Please attach a copy of the front and back of your insurance card.**

Thank you

_____ _____/_____/_____

Client Signature **Date**

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications. I understand that Hippa explanations are available on www.nicolecounseling.com

Client (or guardian):_____ **Date:** _____

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New Client Intake History Form

Client Name: _____
(Last) (First) (Middle)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address: _____
(Number & Street) (City) (State) (Zip)

Phone # (_____)_____ (_____)_____ (_____)_____
Home OK to leave messages? Y N **Work** OK to leave messages? Y N **Cell** OK to leave messages? Y N

Email: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Name of Spouse: _____
(Last) (First) (Middle)

Please list any children/age: _____

Referred by: (if any, or how did you hear of me): _____

Have you previously received any type of mental health services (Counseling, psychiatric services, etc.)?
□ Yes □ No Type of service received: _____

Previous therapist/practitioner name: _____

Have you ever been prescribed psychiatric medication? □ Yes □ No Please list:

_____

_____

Diagnosis: _____

Are you currently taking any prescription medication? □ Yes □ No

Please list **All** Medications you are currently taking:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (Please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____
What type of exercise do you participate in _____
Please list any difficulties you experience with your appetite or eating patterns: _____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes please explain:

Have you in the past or are you currently experiencing any type of abuse?

Are you currently experiencing anxiety, depression, panic attacks or phobias? □ Yes □ No
If yes, please explain your symptoms and when you begin experiencing this?

Have you ever attempted suicide? □ Yes □ No
(If yes, when and how)

Are you currently experiencing any chronic pain? □ Yes □ No
If yes, please describe: _____

Do you drink alcohol more than once a week? □ Yes □ No
How often do you engage recreational drug use?
□ Daily □ Weekly Monthly □ Infrequently □ Never
Do you feel you have a substance abuse problem? If so what substances are you using?

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____
On a scale of 1-10(1=poor relationship, 10=Great relationship) how would you rate your relationship? _____
What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

ADDITIONAL INFORMATION:

Are you currently employed? □ Yes □ No

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? □ Yes □ No If yes, describe your faith or belief:

What do you consider to be some of your personal strengths?

What do you consider to be some of your personal weaknesses?

Why are you coming to counseling? What is the presenting problem?

What would you like to accomplish out of your time in therapy? Is there a specific goal you would like to set?

Is there any other information you feel I should know that may be important?

Client Name **Date**

Therapist **Date**