Kathy Gudonis, MSW, LCSW
New Client Overview

Congratulations on taking a very important step towards healing and wholeness. Please read the First Visit page on our website. This will prepare you for what to expect and provide answers to many frequently asked questions.

Here are a few additional things you should know:

- ***Therapeutic process:*** Therapy or counseling is a process where one can examine and explore their life and feelings in a meaningful, healing way. You are an important part of the process. Together, we will explore symptoms you may be experiencing and decide on goals for our time together. Therapy can be terminated at any time, and it is possible I may refer you to other professionals to assist with your care and well-being.

- ***Limits of confidentiality:*** What we talk about is confidential except if, in my professional judgment, you are at risk of harming yourself or some else.

- ***There are limits to what I can and will help with in this office:*** This setting is more like an office visit to a doctor's office than going to the emergency room. I am not available 24/7 and am not primarily a crisis counselor. If a crisis arises, we will work to contain it and refer you to the appropriate setting and treatment. It is outside the scope of my professional practice to be involved in legal proceedings in any capacity. If that becomes necessary, I can refer you to someone who specializes in that.

- ***I am a mandated reporte****r:* If I hear of abuse/neglect or criminal behavior against a minor – I am required to call the state. I will make a reasonable attempt to notify you before I take any action.

- ***Compass Counseling:*** Each therapist at Compass essentially runs his/her own independent practice. We share facilities and clinical support/consultation in order to offer our clients the best possible therapeutic experience.

- ***Payment:*** The cost for each 55-minute session is $130. You may pay by check or cash; I do not accept credit cards. Payment is due at the conclusion of each session. When paying by check, please make checks payable to Kathy Gudonis.

- ***Cancellation policy:*** You may cancel or change an appointment for any reason as long as you give me 24 hours notice. Without the 24-hour notice, payment is expected for the missed session. Exceptions for urgent medical or personal issues may be made at my discretion.

- ***Insurance reimbursement:*** If you wish to seek reimbursement for my services from your health insurance company, please contact them for an explanation of benefits. This will clarify the terms of your insurance plan, such as whether it will pay for counseling with me, what your deductible is, what your co-pay is, how many sessions are covered, etc. If I am a contracted provider with your insurance company, I will file claims with them for reimbursement; you will be required to pay the co-pay at the time of service. If I am not a contracted provider for your insurance and you have out-of-network benefits, you will be responsible to pay the full rate, and I will give you a statement you can submit to your insurance company for reimbursement. You will also be required to sign an authorization form that allows me to share information with them relevant to the services I provide you.

- ***Complete and bring to first session:*** Intake form, New Client Overview/Counseling Agreement, HIPAA

Kathy Gudonis, MSW, LCSW
Counseling Agreement

I hereby certify that I have read and understand the New Client Overview and I willingly enter into this counseling relationship with Kathy Gudonis, LCSW. I understand that I am personally financially responsible for all charges, and it is my obligation to pay for counseling services provided to (choose one) me____ my child/ward____at the rate of $130.00 per 55-minute session. I understand that full payment/co-pay is due at the conclusion of each session.

If filing with my insurance company, I authorize payment of benefits directly to Kathy Gudonis, LCSW. I also authorize Kathy Gudonis, LCSW to contact my insurance company if any additional information about my coverage is needed, and to release all diagnostic and treatment information essential to complete my claim. My signature below acts as a signature on file, authorizing the release of insurance payments. My signature also authorizes use of a collection agency in the case of unpaid balances with no effort to pay.

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

_____ _____
Signature of Witness Date

Address_____

City_____State_____Zip_____

Client Date of Birth_____Home Phone _____ Cell phone_____

Insurance Information
Primary Policy Holder's Name_____

Date of birth_____

Insurance Co._____

Phone number _____

Insurance identification number _____ Grp # _____

A copy of your insurance card and driver's license are required for your file.

I hereby authorize Kathy Gudonis, LCSW to furnish information to insurance carriers concerning my diagnosis and treatment. I hereby assign all payments for clinical outpatient counseling services to myself or my dependents. ***I understand that I am responsible for any amount not covered by insurance.***