INNER PEACE
COUNSELING CENTER
Support for Individuals, Couples, & Families
Charlotte Location (Colonnade Executive Suites) 1811 Sardis Rd. North, Charlotte, NC 28270
Huntersville Location (Daetwyler Plaza) 13420 Reese Blvd., West, Huntersville, NC 28078

LIMITS OF CONFIDENTIALITY, CANCELLATION POLICY and CONSENT TO BILL

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 service, 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.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) **Today's Date**

Name: _____

I understand this form is to be used when I do not cancel therapeutic sessions within the cancellation terms of the cancellation policy.

Cancellation Policy Acknowledgement

If you should fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for a missed appointments or cancellations with less than 24-hour notice unless it is due to illness or emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Additional Payments Due Policy

It is your responsibility to know and understand the payment terms with your respected Insurance company. If you do not make payment of your copay, or any other payment which, is your responsibility to do as set forth by your insurance company, you understand that we will bill the credit card information below. It is your responsibility to ensure discussion on any payments are done with your therapist respectively. You will receive a bill and later receipt when your card is charged.

Thank you for your cooperation in this matter.

Please use the following credit/debit card:
__ Visa __ Mastercard __AmExpress __Discover

Card Number:_____
Expiration Date: _____
Security Code #: _____
****Please be sure the above address corresponds with your c-card billing address*****

_____ _____
Client Signature (Client's Parent/Guardian if under 18) Today's Date