Mitchell Counseling Services

Joyce S. Mitchell, M.Ed., LPC
404 Galleria Drive, Suite 4
Oxford, MS 38655
Telephone: 662-832-2288 Fax: 662-236-9310
jsmitchl@hotmail.com

CLIENT INFORMATION

Today's Date _____

Client Name: _____ DOB: _____ Age: _____

Address: _____City _____

State: _____ Zip: _____ Contact Phone Number: _____

Marital Status (circle one) M S D W Sex: M F

Occupation: _____

Employer: _____Social Security # _____

Source of referral? (please check one box):			❑ Dr. ❑ Internet:	❑ Insurance Plan or ❑ EAP	❑ Hospital
❑ Family	❑ Friend	❑ Names & Numbers	❑ Yellow Pages	❑ Other	

Responsible Party Information (Required if filling out for a minor)

Parent's Names:_____

Address:_____

_____Contact number: _____

Insurance Information

Primary Insurance Co. _____

PLEASE NOTE: Your signature below indicates that you have read the attached agreement and agree to its terms. You also agree to authorize the clinician to file for benefits and the release of information to your insurance carrier. (A copy will be provided to you for your records)

Signed _____ Date _____

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CLIENT AGREEMENT

_____(initial) I hereby assign payment of authorized psychological benefits to Joyce Mitchell, L.P.C., for any and all psychological services provided. I authorize release of any information needed to determine the benefits payable for related services. In accordance with my right to privacy, information will be shared only with those directly associated with benefit determination and only as relevant to making benefit determination. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for charges whether or not paid by said insurance.

_____(initial) If this account is assigned to an attorney or agency for collection and/or suite, I agree to pay the provider's court cost and attorney's fees. I give my consent for this practitioner to render treatment on the above-mentioned patient for mental health services.

*Note: There may be additional fees if you, or someone representing you, make a request for Written Reports that include but are not limited to File Summaries, Note Production, Release of Information, Preparation of Forms, Recommendations as a result of Counseling, and Verification of Attendance.

The following fees may apply:

1. Written Reports $85.00 hour
2. Copies $20.00 for pages 1-20. $1.00 per page for the next 80 pages, and 10% of total may be added for postage.
3. Court Preparation/Testimony: $250.00 per hour

_____(initial) Potential Duty to Warn – There are exceptions to the ability to protect confidential information provided to us. Under Mississippi law, healthcare professionals are required to report reasonable suspicions of abuse and/or neglect of children and vulnerable adults. Also, when a client discloses intentions or a plan to harm another person or persons, the healthcare professional may be required to warn the intended victim and/or report this information to appropriate legal authorities. If a client discloses or implies a plan for suicide, the healthcare professional may be required to notify appropriate persons for the protection of the client's safety.

_____(initial) If no insurance is being filed, an hourly rate of $90/session will be charged. Additional charges will be added for lengthier sessions.

_____(initial) It is understood that a 24-hour notification to your therapist is an expected courtesy if you wish to cancel an appointment that was reserved to you. Appointments not canceled within 24 hours prior to the appointment may be counted as one of your sessions.