COMPASSIONATELY ROOTED

COUNSELING AND THERAPUTIC PRACTICES

SCOTT W. MATES, LCSW

8401 Patterson Ave Suite 205
Richmond, VA 23229
www.scottmateslcsw.com

P: (804) 912-4950
F: (804) 414-7742
scottmateslcsw@gmail.com

CLIENT FACE SHEET

Today's Date: _____ Referred By: _____

Full Legal Name of Client: _____

DOB: ____/____/_____ Age: _____ Gender: _____ SSN# _____-___-_____

Address: _____ City: _____ Zip code: _____

Contact Phone: _____ Cell: _____ Other: _____

Email: _____

Emergency Contact: _____Best Contact#: _____

If applicable, Parent(s) Name: _____Best Contact #: _____

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Insurance subscriber (Policy Holder): _____

Insured's employer: _____ Relationship to subscriber: _____

Subscriber's DOB: _____ Subscriber's SSN: _____-___-_____

Subscriber's Address: _____ City: _____ Zip code: _____

If under the age of 18, Parent(s)/Guardian must sign giving consent to provide services.

_____ _____
Signature and relation (self/parent/guardian) Date

_____ _____
Signature of additional client including minor Date

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INFORMED CONSENT AND SERVICE AGREEMENT FOR THERAPEUTIC SERVICES

Welcome to Compassionately Rooted Counseling and Therapeutic Practices. I, Scott W. Mates, LCSW Registered Play Therapist, provide psychotherapy sessions to clients on a fee for service basis. Psychotherapy is a professional relationship between a client and a therapist that involves both risks and benefits. You have rights and responsibilities as a client, and I have rights and responsibilities as a therapist. This document serves as an agreement between you (the client) and me (the therapist). The law requires that we obtain your signature acknowledging that we have provided you with this information at the first session. **Although these documents are long and sometimes complex, it is very important that you read them carefully**. We can discuss any questions you have about the procedures at that time.

BENEFITS AND RISKS

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as: anxiety, depression, guilt, frustration, anger, loneliness, and helplessness because psychotherapy often involves discussing some difficult aspects of your life. It is important to share that research has revealed that psychotherapy can yield long term benefits. You are responsible for being an active participant in your therapy and care. Therapy often leads to a significant reduction in distress and mental health symptoms while improving quality of life, relationships, self-awareness, insight, and improved problem-solving skills. There are no guarantees about what will happen. To yield the best results, it is important for you to be active in your treatment plan goals, participation, and follow through with practices outside of session. Therapist has the right to terminate the therapeutic relationship. Should termination occur, therapist will provide a list of referrals if appropriate.

APPOINTMENTS: SCHEDULING, CANCELLATION and ATTENDANCE

Typically, sessions are 45-55 minutes in duration and occur once a week; although, sessions can be frequent as needed and depends on what is clinically appropriate. A late cancel or no-show appointment hurts at least three people: you, your therapist, and another client who could have potentially utilized your time slot. Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the wait list, or a client with a clinical emergency. If you are unable to keep your appointment or are running late, please contact me. If you arrive late to session, more than 15 minutes, your appointment is forfeited, and you will be billed for the total amount of the session even if there is time remaining in your session. Note that at least a 24 hours' notice is needed to cancel an appointment to avoid a fee. **Appointment times that are cancelled without a 24-hour business day (does not include weekends and/or holidays) notice and is not an emergency will incur a fee of $180.00.** Please note that events do not include illnesses- virtual sessions are always an option for meetings. Check with your insurance provider to verify if they cover such services. **It is important to note that insurance companies do not reimburse for any missed appointment fees; you will be responsible for the full payment and payment will be charged to the credit card on file.**

If you engage in chronic missed appointments, I reserve the right to discontinue services at which time you will be responsible for obtaining a new therapist. If you miss an appointment and do not contact therapist within 7 days to discuss and/or reschedule, it will be assumed that you have decided to terminate services and you are responsible for

obtaining a new therapist and/or reinstating your services with me. When you discontinue scheduling sessions, you will be discharged after 2 weeks of non-attendance in therapy when special circumstances have not been discussed.

It is important for you to understand that you may not always can reschedule easily for the same week in which you cancelled or missed an appointment. You may not always be able to secure times for your child for after-school appointments as these are the most popular times, so they are scheduled out soonest. However, I will always do my best to work with you on your scheduling concerns. I do not see any clients on weekends.

PROFESSIONAL FEES

My practice is a fee-for service practice, which means that your payment is expected at the end of each session unless we make other arrangements. I will submit electronic insurance claims to your provider if you request me to do so.

Schedule of Fees:

Initial Assessment: $200.00
Subsequent Sessions: $180.00
Late Cancellation Fee: $180.00
No Show Appointment: $180.00
Returned Check Fee: $50
Treatment Letter Request (fee based on length of time required)
Record Copying fee: $10 and per page rate
Court Fees: **SEE COURT ACTION/LEGAL FEES ADDENDUM**

If you refuse to pay any incurred fees, I reserve the right to use an attorney or collection company to obtain finances for services as agreed upon in this service agreement as well as the cost incurred to me to obtain payment for services. I also reserve the right to increase fees in the future to a reasonable amount and you will be given adequate advanced notice should this occur.

In addition to weekly appointments, it is my practice to charge a pro-rated fee of the hourly cost for other professional services that you may require such as report writing, telephone conversations over 10 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other services which you may request of me that is in my scope of practice. There is a separate court appearance policy that you will be required to review and sign.

SQUARE INVOICES

I use Square to generate and send invoices in situations when sessions are virtual or when the financial responsible party is not present with payment. An invoice is sent through Square via email following the session. Reminders for payment will be emailed as a courtesy. Any invoices outstanding after 5 days will be charged to the credit card on file. Note: all credit cards charged by the practice incur a processing fee. Please see the Credit Card Authorization Form for a list of percentage fees.

CONTACTING ME

Telephone: All clients can contact me via phone with the phone number provided: **(804) 912-4950**. My line is direct and has a confidential voicemail. You may text me at this number as well. Please keep text messages brief and related to issues around cancellations, reschedules and/or tardiness of a scheduled appointment. Please note that I do not conduct therapy through text messages. Please note that due to my work schedule, I am often not immediately available by telephone, and I will not answer the phone when I am with a client. I am not able to offer 24-hour care as I am not a crisis on-call counselor. I cannot be reached after 7pm during the week and cannot be reached during weekends/holidays. When I am unavailable, my telephone is answered by a confidential voicemail that I monitor

frequently throughout the day during the work week. I will make every effort to return your call within 48 hours, except for weekends and holidays. If you do not receive a call back, please assume the message has been lost and try contacting me again. I will make every attempt to inform you of any planned absences of mine. If you need to converse between sessions, any telephone conversations will be charged at the hourly rate. **If for any reason you are experiencing a life-threatening emergency or mental health crisis, please call 911 or visit your local emergency department. You may contact your local County Crisis Services as well: Richmond: 819-4000, Chesterfield: 748-6356, Henrico: 261-8484, Hanover: 356-4200 or go to your local emergency department.**

Email: Email communication is not secure and could be read by others as messages are stored on remote servers. If you choose to contact me via email you are accepting those privacy risks. I recommend using email for scheduling and administrative purposes, rather than a means of communicating and engaging within discussion which includes personal and identifying information regarding my clients. You should also know that any emails I receive from you and any responses that I send to you become a part of your medical record. Please note that I do not conduct therapy across email.

Social Media: I do not interact with clients using social media. I will not accept friend or contact requests from current and/or former clients on any personal social networking sites (Facebook, LinkedIn, Instagram, Twitter, TikTok, Snapchat, etc.). If you have any questions about this, please bring them up when we meet and we can talk more about it.

CONTACTING ME & OUTSIDE CONTACT

My professional ethics require me to avoid dual relationships with clients, which means that I do not socialize or create friendships or romantic/sexual or business relationships with my current or former clients. If our paths cross outside of counseling, to protect your privacy, I will not approach or acknowledge you unless you do so first. If you decide to say hello to me in public, I will welcome that, but I will not introduce you to the person(s) I am with to protect your privacy. You should also know that if I am with others, then it may be best to avoid any acknowledgement because those I am with will ask about our association and although I will not provide them with any information, your confidentiality on some level will be broken.

INSURANCE COLLABORATION

I participate with various insurance provider panels. If you have health insurance with a company that I am paneled with, I will submit claims for my services to the insurance company as a courtesy. **You are expected to pay your copayment at the time of each scheduled session.** If your insurance company does not reimburse your claim, you are responsible for the entire cost of services provided to you. If I am not a provider for your insurance company, you may have access to “out-of-network” reimbursement for your payment to me. It is your responsibility to know your insurance coverage and for letting me know if you have changes in your insurance. You authorize me to submit claims to your insurance company and any supporting information or documentation regarding services provided and reimbursement.

You should also be aware that insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

NO SUPRISES ACT: GOOD FAITH ESTIMATE

"No Surprises Act" requires practitioners to provide a "Good Faith Estimate (GFE)" to individuals who are uninsured or utilize self-pay. Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal Health Care Program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request, or at the time of scheduling health care items and services to receive a GFE of expected charges. Note: The PHSA and GFE do not currently apply to any individuals who are using insurance benefits, including "out of network benefits" (i.e.., submitting superbills to insurance for reimbursement).

RECORDS AND DOCUMENTATION

I am required to keep records of the therapeutic services that I provide to you. Your records are maintained by an electronic health record software and a secured location behind locks. I keep brief records that notate you were seen, your reasons for seeking therapy, your diagnosis, your treatment plan, topics we discuss, your medical, social, and treatment history, records obtained from other providers who are involved in your care, and your billing records. Except in unusual circumstances that involve danger to you, you have the right to inspect your file and have the right to a copy of your file which incurs a flat fee ($10.00) and a fee for copying based on number of pages (pages 1-50 at $.50 per page; pages 51+ at $.25 page). Because these are professional documents, they may be misinterpreted and or upsetting to read by untrained readers. For this reason, I recommend you initially review your documents with me. I require that a request for copies of medical records must be in writing, dated and signed by the person making the request, and include a reasonable description of the records sought. Please allow up to 15 days for this request to be filled. The only way that I issue medical records is in hard-copy paper format. I will not send these documents in the mail and require that the records be picked up from my office to ensure confidentiality. Please note that when you take possession of a copied mental health record, I am not able to secure the privacy of that record as it is in your possession.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy are fully described in a separate document that you received entitled “Notice of Privacy Practices.” You have been provided a copy and we have discussed the limits of confidentiality. Please note that I can not guarantee any confidentiality through email communications and recommend that you not contact me via email other than for scheduling reasons. If you have any further questions at any point in your care, we can have an open discussion at any time.

Therapy sessions with me are strictly confidential, however there are some circumstances when disclosure can occur without your prior consent. The following are possible situations that may limit confidentiality:

1. a) For purposes of supervision or consultation
2. b) Concerns that a client is a danger to himself/herself or someone else
3. c) The disclosure or suspicion of abuse, neglect, or exploitation of a child, elderly, or disabled person
4. d) The disclosure or suspicion of sexual misconduct or unethical behavior of another mental health professional
5. e) Ordered by the court to disclose information
6. f) Written consent to the release of information by the client/their parent/guardian
7. g) Otherwise required by law to disclose information.

MINORS & PARENTS (SEE ADDENDUM BELOW)

Clients under 14 years of age who are not emancipated, and their parents should be aware that the law allows both parents to examine their child’s records unless there is court documentation to indicate otherwise or I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child client between 14 and 18 and his/her parents allowing me to share only

general information about the progress of the child's treatment and his/her attendance at sessions. This means, for example, that I would not share information regarding drug/alcohol use or the sexuality of the minor. If requested, I can provide parents with a summary of their child's treatment when it is complete (see the above information under Records and Documentation). Any other communication will require the child's authorization, unless I feel that the child is in danger of killing him- or herself or is a danger to someone else, in which case, I will notify the parents. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

SPECIAL CONISDERATIONS FOR PARENTAL DISPUTES/DIVORCE

When working with children of divorced families, I require a copy of the current, standing court order(s) that demonstrate custodial rights of each parent; or a parenting agreement that has been signed by both parents and a judge before I begin work with a child and/or family. The parent who is initiating counseling services must have legal authority to make medical decisions for the child. It is the parents and/or legal guardian's responsibility, not this therapist to inform the other parent of the child's involvement within counseling. It is usually in the child's best interest to have both their parents and/or legal guardians be involved in their counseling, if possible, therefore I will make every effort to involve both parents within the process of counseling and am available for consultation to each parent should the need arise. I will always offer and encourage opportunities for both parents and/or legal guardians to be involved throughout the counseling process.

It is very important for parents and legal guardians to recognize that when I am working with your child, my role is to provide counseling services to your child. This means that my role is to be solely focused on the best interests of the child; I will not allow myself to become allied with any disrupting party and/or familial side. Please be aware that any information that is shared with me regarding another parent or individual involved with the caring of the child will become a part of the clinical record and might be shared at some point with the other party.

I ask that you respect your child's time with me. Should you find it necessary to provide me with updates at the time of your child's session, please talk with me about such so that we can figure out the most appropriate way to manage such and limit any disruption that your updates might have upon your child's therapy session.

At times, parents who are involved in divorce or custody disputes have difficulty maintaining an appropriate decorum in the waiting room or office. Out of concern for your child, parents are reminded to behave respectfully to one another in my office and in this building. If parents do not behave in a civil manner, they may be required to attend sessions separately, end a session or we may even terminate services to spare your child.

COURT RELATED CASES (SEE ADDENDUM)

There may be a time during your treatment that either yourself or your child for who I am providing services may have me subpoenaed to court for the purpose of litigation. I generally ask that my clients waive their right to subpoena me to court for any reason if possible. It is my desire and ethical obligation to preserve the confidentiality and trust that is established in the counseling and therapeutic relationship between myself as therapist and client, whether child or adult. Having me and/or my records subpoenaed can damage this process and could potentially have detrimental effects upon the relationship. I will not willingly attend court or deliver my records unless a valid subpoena is issued. Please note that if you chose to subpoena me to court at any time that you will be responsible for all charges involved. Court related services are not covered by insurance.

Court expenses can sometimes include the following and all will be subject to fees for service: Research and reporting writing, Depositions, Travel time and Lodging (if more than 90 minutes away from my office), Communication requested by attorneys and/or other professionals and individuals involved within the case, Making copies or records, Parking, Etc. If I must seek legal consultation regarding any issues involving you and/or your child, please note that you will be responsible for any charges incurred.

Please be aware that I am not a custody evaluator which means that I will not provide any recommendations on custody matters pertaining to your child and/or your family. I can refer you to a custody professional who is able to provide custody evaluations should that need arise. Occasionally, I am asked by a parent and/or legal guardian's attorney to provide records or testimony about treatment to the court. Such a request constitutes as a "dual role" relationship. A "dual role" relationship meaning that I would be expected to provide services for conflicting roles (i.e., parents witness and child's therapist). Such a request could ultimately disrupt and damage the therapeutic relationship and bond between therapist and child; therefore, it is my policy to not engage within such. I have an ethical duty and responsibility to refrain from such situations. In cases where the court has appointed a custody evaluator, guardian ad-litem or parenting coordinator, I will provide information as needed assuming that all appropriate releases of information have been signed or that a court order has been provided to me.

WEAPONS

During appointment times, there are no weapons of any kind allowed in the building or on the premises. Communications of threat to staff, employees or other consumers is prohibited. Brandishing of firearms with or without a Concealed Weapons Permit is strictly prohibited. Only weapons allowed on property are those being carried by active-duty law enforcement in uniform.

WEATHER POLICY

In case of inclement weather, I follow the Henrico County Schools official delays and closings. If the county's public schools are closed, you can automatically assume that your session will be cancelled that day unless you hear from me otherwise. You do not need to call the office to inquire. For the Henrico County School's decision listen to your local radio station, tune into your local news station or log on to https://henricoschools.us/closings-delays/ for closing and delays.

AUDIO RECORDING DEVICES

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited within these offices. My policy is that all audio recording devices including cellphones be turned off during sessions. Please note that if you refuse to stop the recording, it is within the purview of the practice to require you to leave the premises. Thank you for your understanding and compliance.

TYPES OF PAYMENT ACCEPTED

Cash, check and most major credit cards accepted for payment. Please note that no change is kept on the premises. Percentage fees apply to credit card transactions. Please see the Credit Card Authorization form below

ENDING THERAPY

Some clients benefit most from a brief involvement in therapy whereas others will find an extended length of time more valuable. I am committed to working with you if the therapeutic process is productive and healthy. I am available at any time during the therapy process to discuss concerns you may have regarding the ending of your therapy. The process of ending therapy may be equally as significant as the work you accomplish during your therapy. The ending of therapy will

have the most impact when it evolves from a partnership between client and therapist. It is most productive if you can address the ending of your therapy over the course of several closure sessions.

If I do not have contact or communication from you for a period of 30 consecutive days, I will assume that you no longer intend to remain active in this therapy relationship and your case will be closed. You have the option, however, to contact me again any time in the future to discuss continuing psychotherapy with me.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk to me about it so that I can address your concerns. I will handle your concerns with respect and diligence. You may also request that I refer you to another therapist and you are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, gender, sexual orientation, age, religion, national origin, or your source of payment. You have the right to ask about any aspects of therapy and about my training and experience. You have the right to expect that I will not have sexual or social relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Please initial indicating your understanding and agreement to the following:

_____ I have read and understand the informed consent document here and agree to voluntarily enter myself and/or my child into counseling services at Compassionately Rooted Counseling and Therapeutic Practices.

_____ (If applicable) I have managing conservatorship or legal guardianship over my minor child. If child is named in a court document, I have produced the legal documentation to provide such. I agree to promptly notify the therapist should my legal status as a parent or guardian over the above minor child change.

_____ I have been provided with a copy of the Notice of Privacy Practices (HIPPA).

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Date

I, ***Scott W. Mates, LCSW***, have met with this client and/or his or her parent or guardian for a suitable period of time, and have informed him or her of the issues and points raised in this document. I have responded to all of his or her questions. I believe that this person is fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

_____ _____
Scott W. Mates, LCSW Date
Licensed Clinical Social Worker # 0904008309
Registered Play Therapist

□ Copy accepted by client □ Copy kept by therapist

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NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

CLIENT NAME: _____

CLIENT DOB: _____

CLIENT SSN#: _____

I hereby acknowledge that I have received and been given the opportunity to read a copy of Scott W. Mates, LCSW, DBA: Compassionately Rooted Counseling and Therapeutic Practices' *Notice of Privacy Practices* and *Informed Consent for Psychotherapy*. I understand the limits of confidentiality as they were provided to me in writing and explained verbally. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact: Scott W. Mates, LCSW at (804) 912-4950.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Scott W. Mates, LCSW Date
Licensed Clinical Social Worker # 0904008309
Registered Play Therapist

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CREDIT CARD AUTHORIZATION

If you have any concerns regarding any part of this fee structure or payment/billing policy, please discuss it with me as soon as possible. This form will be stored in a secured clinical file and can updated upon either of our requests at any time. This form secures payments as agreed upon in the Informed Consent Agreement. A deposited check in the amount of one full session ($180 may be made in lieu of storing your credit card payment). At the conclusion of services, the $180 check deposit will be returned to you if not used. **There is a 2.6% plus $0.10 fee for every credit card transaction processed in person. Transactions processed without the card present are processed at higher Square fees (2.9% plus $0.30 for invoices through email and 3.5% plus $.15 when processed by practice).** If you want to avoid the cost of CC processing fees, you are more than welcome to pay for your cost of services using cash, money order or check. All payments for services will be collected before next scheduled session occurs- the carrying over of balances will not be permitted unless special arrangements are discussed and agreed upon. **Any invoices created through Square older than 5 days will be automatically charged to the card left on file. Any charges that are declined will result in a temporary hold on services until the balance is paid or another credit card is left on file.**

My signature below authorizes Scott W. Mates, LCSW, LLC, to bill my credit card for professional services rendered to myself that are not paid at the time of services or for situations that are under the late/missed appointment fees policy. I understand that late cancellation and no-show fees will be billed at the time of the appointment. I agree that I will not dispute valid charges as agreed upon. A dispute of these charges can and will result in termination of services.

- **A late cancellation fee of $180.00 if the session is cancelled or rescheduled with less than the 24-hour notice as outlined in the Consent to Treatment Agreement. _____ (Please initial here)**
- **A no-show fee of $180.00 for not showing to a scheduled appointment without said notice, as outlined in the Consent to Treatment Agreement. _____ (Please initial here)**
- **Telephone contact more than 10 minutes that is associated with services that will be prorated of hourly rate of $180/hour. _____ (Please initial here)**
- **Completing forms such as Medical/FMLA/disability paperwork per your request that are prorated in increments of my hourly rate of $180/hour. _____ (Please initial here)**
- **Any fees associated with the writing of letters, preparation of documents and/or any court related fees as outlined in the Consent to Treatment Agreement and the Court Appearance Policy. _____ (Please initial here)**

Checks that are returned will incur a fee for the check and a $50 bank fee or equal to what is charged to Mr. Mates' business account by the financial institution for the returned check.

Credit Card Type (Please Circle): Visa MasterCard American Express Discover

CC#: _____EXP DATE: _____CVV CODE: _____

Name as Printed on the Card: _____ZIP CODE: _____

Card Holders Signature: _____Date: _____

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Financial Agreement and Credit Card Authorization Form

FEE SCHEDULE:
Therapy Intake session $200.00
Individual or Family therapy session $180.00
Late therapy cancellation (less than 24 hours) $180.00
Missed therapy appointment (no-show) $180.00
Court Appearance Retainer $ 750.00
Court Appearance Fee/Depositions per hour $300.00
Phone Consultation/Professional Fees per hour $180.00

I**NSURANCE PROCESSING**
In accordance with the services that will be provided by Scott W. Mates, LCSW, LLC I hereby agree and authorize my insurance company to pay this agency in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. I hereby authorize Scott W. Mates, LCSW, LLC to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

My insurance company is _____

The amount of my co-payment is $_____ as assigned by my insurance company.

Direct Rate is $_____ (services billed outside of insurance coverage)

Your insurance company may require that you pre-authorize your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, as well as effective and termination dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator.

By signing below, the undersigned affirms that he/she has read, understands, and agrees to the finance agreement as outlined above. I authorize my insurance company to make payments directly to Scott W. Mates, LCSW, LLC for services rendered.

Printed Name: _____

Signature: _____ Date: _____

Insurance Decline / Self Pay

If you do not wish to use your insurance to cover and or reimburse you for the cost of psychotherapy services, please read, sign and date below:

I hereby ***do not*** authorize Scott W. Mates, LCSW, LLC to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

Printed Name: _____

Signature: _____ Date: _____

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Consent to Photograph and Store Expressive Arts

I, **Scott W. Mates, LCSW** and Registered Play Therapist with Compassionately Rooted Counseling and Therapeutic Practices am committed to providing quality assessment and treatment services to individuals, families, and children. As part of this commitment, I often seek out consultation with other professionals and colleagues who share my similar clinical background and expertise. Assessment tasks and treatment services are significantly enhanced using photographing and storing expressive arts products, including photographs of sand trays scenes and scenarios, drawings, or storage of arts and crafts. Pictures may be taken for one of the two specific purposes:

- *Supervision/Continuing Education:* Photographs of art or sand trays assist in reviewing and documenting thematic materials following an individual's session, promoting a more in-depth exploration of the work completed which may include soliciting peer feedback and consultation, or me sharing these pictures with my supervisors for feedback and guidance.
- *Teaching and Training:* Reviewing specific portions of photographed expressive arts products aids in teaching and demonstrating specific therapeutic techniques.

I ensure that these photographs will not include any identifying information or pictures of the individual who engaged within the expressive arts activity. All identifying information is removed prior to using the materials for the above purposes. All photos of art and sand tray scenes are identified by number to conceal and protect the identify of the client, and to ensure confidentiality prior to their use in teaching and training. Your consent is completely voluntary., and non-participation will not interfere with the assessment or therapy service that you have requested.

____ I have read the above consent form and have had the opportunity to ask questions which been answered to my satisfaction.

____ I agree to allow my or my child's expressive therapy work (sand tray or art) to be photographed and used for the following purposes: Supervision/Continuing Education, Teaching and Training.

_____
Client name (please print)

_____ _____
Client signature Date

_____ _____
Parent/Legal guardian signature Date

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F: (804) 414-7742
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AUTHORIZATION TO COUNSEL MINOR CHILD

I (We), _____ give my (our) permission to Scott W. Mates, LCSW to see my/our child,

_____ for counseling with and/or (Name of Minor Child)

without me being present in the same session. I (We) understand that we are the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trusting relationship between the therapist and my (our) child(ren), I (we) give the therapist permission to reveal or withhold information which, in his clinical judgment, is necessary to protect my (our) minor child. The only exception to this discretion would be in the case of:

- ***Concerns that the child is a danger to himself/herself or someone else.***
- ***The disclosure or suspicion of abuse, neglect, or exploitation of a child, elderly, or disabled person as it pertains to the child.***
- ***The disclosure or suspicion of sexual misconduct or unethical behavior of another mental health professional as it pertains to the child.***
- ***Ordered by the court to disclose information.***
- ***Otherwise required by law to disclose information.***

I(We) have legal custody of the child and have authorization to provide counseling for the child named above and accept the responsibility to provide any documentation supporting such should it be requested by Scott W. Mates, LCSW.

Yes ____ No ____ **Please initial here _____**

Does another person or party have the authority to provide consent for medical and mental health treatment?

Yes ____ No ____ (if yes, please list here: _____) **Please initial here _____**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

_____ _____

Parent/Legal Guardian Date

_____ _____

Parent/Legal Guardian Date

_____ _____

Scott W. Mates, LCSW Date
Licensed Clinical Social Worker # 0904008309
Registered Play Therapist

COMPASSIONATLEY ROOTED

COUNSELING AND THERAPUTIC PRACTICES

SCOTT W. MATES, LCSW

8401 Patterson Ave Suite 205
Richmond, VA 23229
www.scottmateslcsw.com

P: (804) 912-4950
F: (804) 414-7742
scottmateslcsw@gmail.com

Court Action/Legal Fees

There may be a time during your treatment that either yourself or your child for who I am providing services may have me subpoenaed to court for the purpose of litigation. Please be aware that I can only testify to the facts of the case and to my professional and clinical opinion. This does not guarantee that testimony will be solely in your favor. The same is true for record requests for the purposes of litigation. Furthermore, when I must go to court, all clients that are scheduled with me for that day will then need to be rescheduled, therefore fees are assessed to make up for lost revenue and my time away from work. These fees are usual and customary, and within the State of Virginia guidelines. **None of these fees are billable to your insurance, and you carry the financial responsibility of the client and/or requestor.**

If I am to receive a subpoena, then the attorney or office staff must contact me to set up a time within business hours to serve the subpoena. A **minimum of 72 hours** will be requested to accommodate and schedule changes. **Any requests that are received with less than 72 hours will be assessed a rushed fee ($300.00).**

Fees for the purpose of court action are as follows:
$300/per hour (billable in 15-minute increments)
$0.54/per mile for travel or IRS federal reimbursement rate at the time of travel
$150 Fee for filing documents with the court.
$750 Court Retainer (due 72 hours in advance)
(Additional cost for lodging and stay should I need to travel more than 90 miles from my office)

Please be aware that the following guidelines apply:

- Scheduling a court appearance must be done at least 72 hours in advance of the court date, and payment for court retainer is due at the time of notice.
- Fees for my time in court is $300 per hour and does not include mileage and travel expenses (if necessary), consultation with your attorney(s), filing documentation with the court or requested written reports or statements.
- The fee to block an entire day of mine from 8:00 a.m. to 6:00 p.m. is $1300.
- Unless you have me block an entire day for court appearance, I will estimate an amount of time reasonable to accomplish the court appearance you are requesting.
- If the court appearance is cancelled and this therapist is not made aware with at least 48 hours' notice, the court retainer fee of $750.00 will not be refunded.

The court retainer fee is due 72 hours before any requested court appearance. The difference will either be billed or refunded following the appearance.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO IT AND ALL OF THE LISTED TERMS

_____
Client name (please print)

_____ _____
Client signature (If Applicable) Date

_____
Parent/Legal guardian name (please print)

_____ _____
Parent/Legal guardian signature Date

_____
Parent/Legal guardian name (please print)

_____ _____
Parent/Legal guardian signature Date

_____ _____
Scott W. Mates, LCSW Date
Licensed Clinical Social Worker # 0904008309
Registered Play Therapist

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CLIENT MEDICAL INFORMATION SHEET

NAME: _____ **DOB:** _____

NAME OF PCP: _____**P:** _____

ADDRESS: _____

NAME OF PSYCHIATRIST: _____**P:** _____

ADDRESS: _____

CURRENT MEDICATION LIST:

MEDICATION NAME	DOSAGE	REASON	PRESCRIBER
1.			
2.			
3.			
4.			
5.			

You may use the back of this sheet if you need more room Medications listed on the back ☐Yes ☐ NO
You may also attach a medication list.

PLEASE LIST YOUR ALLERGIES TO FOOD AND MEDICATIONS:

_____
_____
_____

PLEASE LIST YOUR MEDICAL CONDITIONS:

_____
_____
_____

By signing below, I attest that this information is accurate to the best of my knowledge.

_____ _____

Client/Guardian Signature Date

_____ _____

Scott W. Mates, LCSW Date
Licensed Clinical Social Worker # 0904008309
Registered Play Therapist

MEDICATION NAME	DOSAGE	REASON	PRESCRIBER
6.			
7.			
8			
9.			
10.			