CLIENT INFORMATION

(Must be filled out completely)

NAME_____Address_____

City_____State_____Zip_____Home#_____

Date of Birth_____Age_____M/F____M / S / W / D Cell#_____

Social Security#_____E-Mail Address_____

Employer_____Address_____

City_____State_____Zip_____Work#_____

Spouses Name_____Spouse Employer_____Work#_____

IF CLIENT IS A MINOR
(PARENT MUST SIGN)

Father Name_____Social Security_____

Address_____City_____State_____Zip_____

Phone#_____Employer_____Phone_____

Mother Name_____Social Security_____

Address_____City_____State_____Zip_____

Phone#_____Employer_____Phone_____

INSURANCE INFORMATION

Primary Insurance_____ Secondary Insurance_____

Insured Name_____ Insured Name_____

Insured S.S.#_____ Insured S.S.#_____

Date of Birth_____ Date of Birth_____

PERSON TO CONTACT IN CASE OF EMERGENCY

(Outside your home)

Name_____Relationship_____

Home#_____Work#_____Cell#_____

Primary Physicians Name_____Phone#_____

Who may we thank for this referral?_____

INSURANCE AUTHORIZATION/ASSIGNMENT OF BENEFITS/CONSENT TO TREATMENT

I hereby authorize Clayton Lessor, M.A., LPC to furnish any information concerning my illness and treatment to all insurance carriers concerned and hereby assign all payment for medical services rendered to myself and/or dependents. A photocopy of this will be considered valid as the original. It is the responsibility of each insured person to know their own insurance coverage. I understand that I am financially responsible for all charges regardless of insurance coverage. All deductibles and/or co-payments are due at time of services rendered unless arranged in advance. I further understand that if this is referred to a collection agency, I am fully responsible for all attorney and/or collections fees. I understand that if my appointment is not cancelled within 24 hours of the appointment time, I will be responsible to pay for the missed appointment fees. I hereby give consent for treatment.

I have read and understand the above.

Client Signature_____Date_____

CLAYTON J. LESSOR, LPC
8820 PARDEE ROAD
ST. LOUIS, MO 63123
314.640.1553

FINANCIAL AGREEMENT AND FEE SCHEDULE

1. Charges for services are:
   $160.00 *Initial Assessment*
   $140.00 per hour-*Individual, Couples and Family Therapy*
   $140.00 per hour and half-*Group Therapy Sessions*
   $10.00 per minute-*Phone consultations (not related to scheduling appointments)*

   - You will be charged for 1 clinical hour ($140.00) for all no-show, individual, family and couples appointments and for all appointments cancelled for non-emergency reasons with less than 24-hour notice. Emergencies for which you will not be charged include sudden illness, family death, emergency job requirements and emergency childcare situations.

   - For Group Therapy you will be charged for 1 session ($140.00) according to the same policy described above.

2. Payment is due at the time services are rendered, unless other arrangements have been made with your therapist. **Insurance will not pay for missed appointments and phone consultations**. You will be fully responsible for such fees. **A $50.00 fee will be charged for checks written and returned due to insufficient funds.**

3. Release: If I am using my insurance benefits, I authorize my therapist to release information required to process my claim.

4. Assignment: If I am using my insurance benefits, and paying only my co-pay, I hereby assign my insurance benefits to be paid to my therapist.

5. I understand that in the event of non-payment of fees, my therapist will seek resolution using my name, address, phone number, outstanding balances and dates of service. This may precipitate legal recourse.

6. Charges for Court appearance: $320.00 per hour plus travel time.

7. Charges for research, reports and/or letter writing: $220.00 per hour, minimum 1 hour.

Signature of Client, Parent or Legal Guardian,_____Date_____

Clayton J. Lessor, LPC,_____Date_____

CLAYTON J. LESSOR, LPC
8820 PARDEE ROAD
ST. LOUIS, MO 63123
314.640.1553

CONSENT FOR TREATMENT

The therapy process is one in which you seek to understand yourself, your feelings, and your concerns more clearly and perhaps to make some changes in your life as a result of what you have learned. My role in this process is to help you gain additional perspective on yourself, your feelings and your life. I will seek, first to get to know you so that I can better understand your concerns. You will aid me in this process by being open and honest in our sessions and providing as much information as you can, concerning issues that trouble you. Occasionally, I may say things that you may find difficult to hear. Your therapy goals will best be achieved if you can remain open to emotions, insights, and ideas which may be different than you have experienced. Because the therapy process sometimes involves an examination of aspects of yourself, which have previously remained hidden, you may be surprised by the intensity of new emotions. Be assured that this is a normal part of healing and change which occurs through therapy.

All of our sessions are confidential. The ethics of my profession prevent me from discussing you or our situation outside of our sessions with the following exceptions: 1. If someone is in danger of being harmed (you or someone else). 2. If I become aware of the existence of child abuse-physical or sexual. 3. If my records or I am subpoenaed by a judge. 4. If you give me written permission to release your records to another party. To maintain the highest quality of service for my clients-I may, at times consult with a colleague.

You have many rights as a client under my care. Several of them have been granted to you by the information contained in this document. Specifically, you have the right to:

- Have knowledge of my qualifications and training.
- Be fully informed regarding the conditions under which services will be provided to you.
- Discuss your therapy with anyone you choose.
- Request an explanation of any procedure or form of therapy used in your treatment.
- Review your file with me and have summaries of your file released to other professions with your written request.
- End therapy at any time, hopefully after you have discussed your reasons with me.
- Question my competence and file formal complaints with appropriate professional and/or legal bodies if you believe that I have delivered services to you in an unethical manner.

Above all, you have the right to ask me questions. If there is something that confuses you, please feel free to ask me questions and expect an explanation that you understand.

It is your responsibility to notify me at least 24 hours in advance of any scheduled appointment, which you will be unable to keep. The normal fee will be charged with less than 24 hours notice, except in the event of an emergency. I would also appreciate you letting me know when you are no longer interested in my services. It is your right to end services at any time. However, "dropping out" without notifying me is an inconvenience and may delay services to someone else.

While you are in my care, I will be available as much as possible. In case of emergency you may leave a message at the office 314.640.1553 or go to the nearest emergency room.
If you have any questions or concerns about the information contained in this document please discuss them with me at your earliest convenience.

I have read the above information and I consent to participate in psychotherapy as described above. I give consent for Clayton J. Lessor, LPC, to exchange/release information for the purpose of coordinating services

To:_____.

_____ _____

Client Signature Date Therapist Signature Date

CLAYTON J. LESSOR, LPC
8820 PARDEE ROAD
ST. LOUIS, MO 63123
314.640.1553

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

I, _____, DOB _____, for the purpose of coordinating care, authorize Clayton J. Lessor, LPC, to release information related to my evaluation and treatment to:

PCP Name:_____Phone:_____

PCP Address:_____

PCP Fax Number:_____

INFORMATION FOR PCP

The client was seen by me on_____for (diagnosis)_____

Treatment plan is:

_____

_____

_____

Provider Signature_____

CONSENT

I, undersigned, understand that I may revoke this consent at any time except that action has been taken in reliance upon it and that in any event this consent shall expire 6 months from the date of signature.

_____

Client Signature

_____

Client Signature Parent/Guardian signature for clients under the age of 19