FREEDOM COUNSELING CENTER

(aka Andros Family Services)
David Andros, MS, LP Licensed Psychologist
Heather Jackowell, MA, LPC Licensed Professional
Counselor 1120 S. Avenue, North Mankato, MN 56003
326 Walnut Street, St. Peter, MN 56082 (mail only)
(507) 934-4160

PATIENT INFORMATION

Client Name		**Age**			
Birth Date					
Address					
City		**State**		**Zip**	
Phone (home)					
Phone (cell)					
Phone (work)					
Employer		**Position**			
Email					

RESPONSIBLE PARTY INFORMATION

Name					
Birth Date					
Address					
City		**State**		**Zip**	
Phone (home)					
Phone (cell)					
Phone (work)					
Employer					
Client Relationship					

INSURANCE INFORMATION

1st Insurance Co.					
Group Number		**Contract Number**			
Address					
City		**State**		**Zip**	
Phone					
2nd Insurance Co.					
Group Number		**Contract Number**			
Address					
City		**State**		**Zip**	
Phone					

I hereby authorize the release of any information by **Freedom Counseling Center** to my insurance company and/or immediate family (in the event of my death) on behalf of myself and/or my dependents.

I give my permission to be called at

Home? ☐ **Work?** ☐

May we text/email/voice mail you for appointment reminders or schedule changes?

Text ? ☐ **Email?** ☐ **Phone?** ☐

I understand that I am financially responsible for charges not covered by my insurance contract and I will be reponsible for payment of the entire bill. I will give a 24 hour notice of cancellation for my appointment or I may be charged for the failed session.

Client		**Date**	
Psychologist or Counsellor		**Date**	
Supervisor		**Date**	

CONSENT FOR PARTICIPATION IN PSYCHOTHERAPY OR TREATMENT

I agree to pay for all services rendered by Freedom Counseling Center (aka Andros Family Services), including counseling and testing and other related services in accordance with the terms set below.

1. The intial diagnostic session is $175. I acknowledge that each 50-minute counseling session is $120. If sliding fee is qualified:

The initial diagnostic session is	
Each 50-minute counseling session is	

2. I agree to pay my co-payment, coinsurances, deductibles, and/or my full fee-for-service at the time of each appointment.

3. I understand that I am personally responsible to know my insurance limits, exclusions, deductibles, and co-payment structures, even though support staff does a preliminary check. I do not hold Freedom Counseling Center responsible for insurance company errors or refusals for reimbursements for services rendered. *I understand I am responsible for all services for which my insurance company will not pay.*

4. I understand that my non-insurance related balance will not be allowed to exceed $300 and that therapy may be temporairly suspended or terminated until balance is lowered.

5. I understand that I am responsible for appointments that are missed or canceled with less than 24-hour notice. If I miss two or more sessions, Freedom Counseling Center reserves the right to terminate therapy.

6. I understand that my treatment may be reviewed confidentially with a consultant or clinical supervisor for assessment, diagnosis, and evaluation of treatment and progress.

7. I understand that all counseling is values-based, and that among the many options available, Freedom Counseling Center represents a Christian perspective. The counseling approach will reflect this perspective and if clinically appropriate and desired by the client, it may incorpoarte prayer, biblical references, and biblically oriented principles. I acknowledge that no guarantees have been made to me as a result of any therapeutic intervention.

8. I have read the above and understand its contents. I agree to abide by the provisions set forth above. I have seen a copy of "Clients Rights and Information" with an opportunity to review it and ask any questions.

Client		**Date**	
Psychologist or Counsellor		**Date**	
Supervisor		**Date**	