Patient Information and Consent to Treatment

Thank you for choosing East Valley Christian Counseling and Jamie Kobsar, MA, LPC for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies of my practice, I am providing the following information.

Appointment: If you need to cancel an appointment, a minimum of 24 HOURS NOTICE IS REQUIRED; otherwise, you are subject to full charge for the appointment. During the evenings or weekends or if I am unavailable, you may leave a message on my phone, which will accurately record the date and time you placed the call. I will do my best to be punctual for your appointment unless I have an emergency call. I ask that you be punctual as well. If you are late, you will receive the remainder of your scheduled time. This is necessary so I can see the following patients at their scheduled times.

Emergencies: I have a 24-hour voicemail service for all after hour emergencies. Please call (480) 284-1456.

Financial Responsibility: You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual arrangements apply. Please make all checks payable to East Valley Christian Counseling. As another payment option, I accept Visa, MasterCard, Discover, and American Express. There will be a $25.00 fee for payments returned and non-sufficient or non-payable. Please Note: billing process may include a monthly statement, phone call, or correspondence with the patient due portion of the account balance. Statements, phone calls, and correspondence will be addressed to the patient/guarantor address or phone number listed on the Client Face Sheet. If any of these business office procedures present a problem for you or your treatment, please discuss your concerns with me.

Insurance Billing: I do not routinely bill insurance, unless I am the contracted counselor with your insurance plan. For non-contracted insurance plans, I require full payment at the time of service and you may bill your insurance company directly with the completed fee ticket you will receive. For contracted insurance plans, your benefits will be verified and your financial responsibility reviewed with you prior to your first visit. You are responsible for co-payment, deductible, and non-covered services as determined by your insurance plan. I will submit the appropriate claim form to your contracted insurance plan for reimbursement. You are responsible for notifying me immediately of any changes to your insurance plan or coverage. Insurance company quoted benefits are not a guarantee payment.

Confidentiality: Your patient records are the property of this clinic and shall be treated as confidential. To comply with state and federal laws regarding patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in strict confidence (with the exception of those situations in which we are required by law to report, including imminent danger to self or others and suspected or reported child abuse). If you chose to have me keep a third party informed of your progress in counseling, it will be necessary to complete a “Release of Information” form that will be kept on file.

Biblically Based Professional Counseling: By choosing this practice to provide your professional counseling, you have also chosen to be seen by a counselor who approaches every counseling situation from a Christian perspective. Attention will be given to the healing of the whole person – body, mind, and spirit – with spiritual matters handled in a distinctly Christian, Biblically based manner. At no time will coercive or manipulative techniques be used, in either spiritual, emotional, and/or relational matters. With your input and discussion, spiritual interventions such as prayer and the use of Scriptures may be utilized, in addition to professional counseling interventions. I will discuss all such problem identification and strategy selection with you in the treatment planning process.

***PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE NOTIFICATIONS AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT BY** Jamie Kobsar, MA, LPC:

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Client/Guardian Date