

WELCOME to "The Couch Doc"

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PLEASE READ BELOW

Accepting insurance does not allow the terms of your treatment to be determined by you as needed, or myself, as I see appropriate—and is usually limited to 16-24 sessions PER YEAR. I will schedule your time and hold it until you notify me you wish to cancel; I will respect your privacy and confidentiality and work conscientiously to provide the highest level of care or referrals. As a courtesy to me, I REQUIRE a credit card on file to protect the loss of time when you do not call and cancel, or have sessions which are not covered under your insurance policy. **YOUR INSURANCE PAYS FOR THE SESSION— YOU WILL PAY IF YOU DON'T SHOW OR CANCEL. WHETHER YOU PAY CASH OR NOT- I REQUIRE A CREDIT CARD ON-FILE.**

1. I understand that my participation in therapy is voluntary and therefore can be terminated without penalty at any time by the client or therapist.

2. There is no guarantee that therapy will be successful. However, current research suggests that increasing the amount of education regarding the functioning of the individual as well as the family can be very effective for some types of problems. My experience is that those clients who follow through with the recommendations, do the homework assignments and have some degree of motivation often reach the goals they have set.

3. The fee of \$100 every 45 minute session is due at the time of service. Longer sessions will be charged accordingly. Phone calls are billed after 10 minutes.

4. Cancellations require at least 24 hours notice. All other cancellations will be subject to the fee of \$65.

INITIAL HERE: _____

INITIAL HERE: _____



PLEASE COMPLETE THE FOLLOWING INFORMATION

Name(s) _____/_____

Date of Birth(s) _____/_____

SS# _____/_____/_____ SS# _____/_____/_____

Insurance? Yes or No

EAP? _____ Self-pay? _____

Home/Billing Address _____

City _____ State/Zip _____

Home Phone_(____)_____-_____ Work/Cell Phone_(____)_____-_____

E-mail _____

May I email you? Yes ___ No___ Gender: F___ M___ _____

EMPLOYER: _____

Emergency contact _____

Phone_(____)_____-_____ Phone_(____)_____-_____

How did you hear about me? _____

If by referral, whom may I thank for this referral? _____

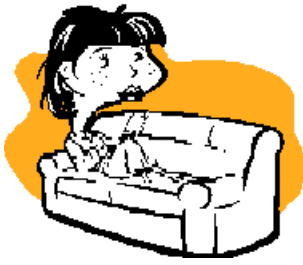
May I mail you information, letters, and correspondence? _____

Have you ever had treatment by a psychiatrist, psychologist or counselor? Yes ___ No___

Please state why you decided to come for counseling/therapy? What are your goals in attending treatment?

(Medications?) _____

YOUR SIGNATURE ON THE NEXT PAGE INDICATES THAT YOU HAVE READ AND ACCEPTED THE TERMS SET BY ME. YOUR BILLING CHARGES WILL BE PROCESSED THROUGH "THERAPYPARTNER" AND BY SIGNING BELOW ARE AUTHORIZING THAT, I, DEBBIE BARBAROUSSIS-GOOT, ND, LMFT, CWC BCPC, WORK AS YOUR THERAPIST.



PLEASE READ THE FOLLOWING BEFORE SIGNING...

CLIENTS HAVE PROVIDED ME WITH WRONG CREDIT CARD NUMBERS AND EXPIRED CARDS AS FORM OF PAYMENT. THEREFORE I AM REQUIRING COPIES OF YOUR INSURANCE AND CREDIT CARD FOR SECURITY. YOU ARE RESPONSIBLE FOR ALL FEES, INCLUDING "CHARGE BACKS". INSURANCE PAYS YOUR VISIT—NOT YOUR "NO SHOW OR NO CANCELLATION".

I encourage you to find and use your insurance if you are unable to pay my fees. Your credit card is *never* charged unless you authorize me for payments, or you have a NO-CALL -NO-SHOW. I am not responsible for your lack of knowledge regarding your deductibles or co-pays.

CARD TYPE—CIRCLE ONE (VISA, MASTERCARD, OR DISCOVER)

CREDIT C#: _____ EXP. DATE: ____/____/____ CVCODE: _____

\$ 100 CASH PER SESSION UNLESS OTHERWISE ARRANGED AND AGREED UPON (INITIAL) _____

\$ 65 NO CALL NO SHOW (INITIAL) _____

\$65 ADMINISTRATIVE FEES FOR LETTERS OR DOCUMENTATION OF ATTENDANCE (INITIAL) _____

BILLING ADDRESS (AS REGISTERED WITH CREDIT CARD COMPANY/BANK):

EMAIL: _____

PAYMENTS ARE

- CASH (\$100)
- CHECK (WITH CK GUARANTEE CARD)
- CREDIT CARD (\$105) (PLEASE NOTE A \$5.00 SERVICE FEE APPLIES IN ADDITION TO THE FEES FOR EACH SESSION OR NO SHOW). THIS IS NOT MY FEE, BUT WHAT I AM CHARGED FOR THE USE OF CREDIT CARDS.

ONCE AGAIN---THERE IS NO CHARGE IF YOU CALL 24 HOURS IN ADVANCE.

SIGNATURE _____ DATE _____

SIGNATURE _____ DATE _____