CLIENT CONTRACT

PLEASE FILL OUT ALL FORMS (3 OF 5)

300 N WASHINGTON ST, STE 304 • ALEXANDRIA, VA 22314
OFFICE 703-518-5184 • FAX 703-518-5185
LINDAKORNETTLCSW.COM

CONFIDENTIALITY

Please be aware that under the provisions of confidentiality between Mental Health Providers and their clients, Linda Kornett, LCSW will not be able to speak to anyone regarding your case without written consent.

There are, however, specific limitations to client confidentiality: in the event of a suspected case of abuse/neglect of children or the elderly, or the commission of a felony, I am required by law to make a report to the authorities. Furthermore, as required by law, when a client voices suicidal or homicidal ideations, Mental Health Providers are required to take necessary steps towards protecting the client or the target of the homicidal ideations. They are also required by law to honor subpoenas.

SIGNATURE _____ DATE _____

INSURANCE RELEASE AUTHORIZATIONS (CLAIMS)

I authorize the release of any psychological or psychiatric information necessary to process my claims regarding my treatment under the care of Linda Kornett, LCSW. I request payment of benefits to be paid to said provider. I also request that the below signature be placed on file to process future claims regarding my treatment with Linda Kornett, LCSW.

SIGNATURE _____ DATE _____

FINANCIAL RESPONSIBILITY

I accept financial responsibility for any and all fees incurred by my family members or myself for services provided by Linda Kornett, LCSW, including those fees which my insurance company, for whatever reason, fails to reimburse. Payment of my portion of fees (co-payment) will be made at the time of each visit. A finance charge of 1-1 ½ % per month (18% per annum) will be assessed in all invoices remaining unpaid. In the event this account is placed with an attorney or collection agency for suit or collection, all professional fees and charges shall be added to the unpaid balance.

SIGNATURE _____ DATE _____

CANCELLATION POLICY

If I must cancel an appointment, I will notify the office at least 24 hours in advance. I understand that a missed appointment without providing any notice will result in a bill of $100.00, which will be due in full prior to my next session.

SIGNATURE _____ DATE _____