www.empowercounseling.info
Phone 434-219-5621 Fax 434-305-1072

Welcome to Empower Counseling, PC. Thank you for completing the following documents to assist you better. Please be advised our counselors practice at different locations. Please see below:

Empower Counseling 1381 Crossings Centre Drive Suite E Forest, VA 24551

Tara Cothren, LPC Adam Cothren, LPC Carley Marcouillier, LPC
Kim Epperly, LPC Debra Crowder, LPC Debbie Kleinsmith, Psy, D
Ryan Smith, LPC Sara Goins, LPC Jane Snider, LPC
LeeAnna Warner, LPC Amy Scott, LPC Trish McCoy Kessler, LPC, CEDS-S
Jordyn Chaverri, Resident in Counseling Christina Cunningham, Resident in Counseling
Geoffrey Dill, Resident in Counseling

Empower Counseling, PC- Graves Mill 1610-A Graves Mill Road Lynchburg, VA 24502

Emily Woody, LPC Amy Scott, LPC Gabbie Mauk, LPC
Gwen Seiler, Resident in Counseling Beth Girts, Resident in Counseling Skylar Turner, Resident in Counseling
Sherri Meyer, MS, RD, CEDS

Telehealth:

Sandra Noble, PhD, LPC, CEDS, NCC

Billing/Office Manager: Christy Trent
Receptionist/Scheduler: Jessie Beaumont

Thank you!
Trish McCoy Kessler, LPC, CEDS-S, Owner

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Forest VA 24551
And
1610-A Graves Mill Road
Lynchburg, VA 24502

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Rates for 2023-2024 CLIENT SERVICES AGREEMENT

1. FEE SCHEDULE. Payment for services is required at each session. The fees are as follows:

Intake (First Session) $143.00
Therapy Session...$139.00 (60 minutes)
Therapy Session...$93.00 (45 minutes)
Therapy Session...$70.00 (30 minutes)
Therapy Session Family w/client...$106.00
Therapy Session Family without client..................................$102.00
Telephone consultations exceeding 15 minutes not covered by insurance.........$20.00 per 15 minute
Increments for telephone consultations exceeding 15 minutes. Not covered by Insurance.
Report Writing for Schools, Physicians, or other correspondence.........................$35.00
Registered Dietitian Intake...$175.00
Registered Dietitian Follow Up Appointments......................$125.00

-Court appearances and contacts with attorneys follow the fee guidelines established by the Lynchburg Bar Association and the Lynchburg Academy of Medicine. Guidelines are available upon request.
-Insurance reimbursement is the client's responsibility. However, our office will provide assistance with filing claims as needed. Please note: Insurance companies do not reimburse for court appearances, phone consultations, /calls, or missed appointment fees.

2. COLLECTION OF FEES. Any expenses incurred in the collection of fees are the sole responsibility of the client. Such expenses may include, but are not limited to, attorneys' fees or collection agency fees. There is a charge of $25.00 for any returned check.

MISSED APPOINTMENTS. There is a charge of $100.00 for any appointment not canceled 24 hours in advance. To cancel a Monday appointment and avoid this charge, you must call by 5:00pm on the previous Friday. Our office **requires** a credit card to keep on file for the charge of missed appointments.

3. EMERGENCIES. In the event of a true emergency after hours, you may call Trish McCoy Kessler, LPC, CEDS-S/Owner on her cell phone: (434) 238-5975. Please leave a message. If you do not hear back from her or your therapist within 15 minutes, please contact your family physician, psychiatrist, the Lynchburg General

Couples Informed Consent Form

DOCUMENTATION OF INFORMED CONSENT FOR TREATMENT:

COUPLES THERAPY

We understand that couples therapy begins with an evaluation of our relationship, past and present. While ___________________ is deciding whether she is the appropriate therapist for us, we will decide whether we wish to begin couples therapy with her. We understand that because of the commitment of time and money, plus the potential impact on us and others (see below), it is important to make an informed choice for a couple's therapist.

We have read and understand the potential limits of confidentiality, including those imposed by Empower Counseling's policies and by state law, and we have received a copy to keep. *[If we have dependent children, we have read and understood the potential limits of confidentiality regarding access to records in child custody cases].*

We understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena the counselor to testify for or against either party or to provide records in a court action.

We understand all policies as described on the PATIENT INFORMATION sheet and accept them as conditions for entering couple's therapy. We understand the limits and benefits of using insurance to pay for couples' therapy. If we use insurance, we agree to provide all information needed to comply with insurance regulations. We understand that if we use insurance, the therapist will not retain control over information provided to the insurance company.

We were given the opportunity to ask questions and discuss confidentiality and disclosure policies with the therapist. We understand that while working as a couple, anything either of us might say to the therapist individually, whether by phone or in an individual session, may not be held as confidential, and at therapist's discretion may be shared with the spouse/partner during a subsequent couple session.

We agree to share responsibility for the therapy process, including goal setting and termination. By entering couple's therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. *[This is especially true if we have dependent children.]*

The therapist has explained that the focus in couples' therapy is on preserving and enhancing the relationship rather than a focus on individual happiness. However, if remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation.

We agree to pay for all services provided by the therapist, including any charges not fully reimbursed by the insurance company (if applicable). We understand that no insurance company will pay for missed sessions, and we agree to the policy of charging session fee if we fail to cancel appointments in advance.

By signing below, we agree to accept mental health services and accept full responsibility for payment for such services.

Client_______________________________ **Date**_____________________
Client_______________________________ **Date**_____________________

Therapist ____________________________ **Date** ____________________

Hospital Emergency Room at (434) 200-3033 or call 911. If she is out of town or otherwise unavailable, emergency coverage will be provided by a licensed colleague acting on her behalf.

4. **I have read the above terms and agree to them.**

CLIENT SERVICES AGREEMENT

___ ***If*** using insurance benefits. I also hereby give my permission to release my name, Social Security number, address, and financial information to insurance companies for billing purposes, and to collection agencies, if needed to collet any unpaid bills.

Insurance Company ____________________________ ID#______________________________________

Group#_______________________________ Copay Amount _________________________

____***If*** self-pay account, I understand that discounted fees are not eligible for submission to any third-party payer (i.e. insurance company, public, or private agency/department). I also hereby give my permission to release my name, Social Security Number, address, and financial information to collection agencies, if needed to collect on any unpaid bills.

____

Date

x____

Signature of Client (or Legal Guardian)

x____

Signature of Client (if age 14-17)

x____

Printed Name of Client

SSN# ________________________

X__________________________________

Signature of Witness

Payment Policy and Procedure Agreement

- Payment is required at the time of service.
- If you are unable to keep your scheduled appointment, please call 24 hours in advance to cancel. **There will be a $100.00 missed appointment fee charged for less than 24 hours notice or if you fail to show with no notice**.
- If your balance exceeds **$300** and you have not made a payment, or we have not received payment from your insurance company we will be unable to schedule an appointment until the balance has been reduced.
- We require keeping a credit card on file to be charged in case of either of these events.
- Please initial here if you would like to have this card charged for copays, co-insurance or deductibles for each visit. _________

Client Signature

____

Date

Credit Card Information

Master Card   Visa   Discover   AMEX   Other _____   HSA/FSA

Cardholder Name ________________________________

Card Number ______________________________________ CRV ________

Expiration ________________ Zip ______________

Client Signature ______________________________

_______ I decline to give my credit card information.

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Personal History Form

Name: ______________________________ Social Security #____________________

Gender: __________ Date of Birth: ____________________

Address:
____________________City____________________State______Zip__________

Phone (Home):____________(work):____________ext:______(Cell): ______________

Email: ____________________ Preferred Method of Contact: ____________________

Person responsible for bill:____________________Phone:____________________

Email:____________________ May we send statements to this email or the above email? Yes or No

Family Members Living in the Household

Relationship	Name	Age	Phone (If Applicable)

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Couple Counseling – Individual Personal History Form

Identified client ___ **Y** ___**N**

Name__________________________________ **DOB** _________ **Sex/Gender** _________

Name of partner ___________________________ **DOB** __________ **Sex/Gender** ________

Marital Status ____________ How **long have you been in this relationship?** ____________

Number of Children & ages ____

Your Address ____

Your Phone (Home) ________________________ **Phone (Mobile)** ____________________

Your email address ____

What problem(s) led you to seek couple's counseling (top 3 concerns)? _________________

____

____

What have you tried so far to deal with your difficulties as a couple? ___________________

____

Prior counseling (where, when and outcome)? _____________________________________

____

____

What goals do you hope to achieve from counseling now? ______________________________

____

____

What initially attracted you to your partner? ______________________________________

What happened that first caused you to feel disillusioned with your partner? ____________

____

What if any changes have occurred from this disillusionment? _________________________

____

How long has it been since things were good between the two of you? __________________

How are the two of you similar and how are you different? ____________________________

____

When there is conflict between the two of you, what do you do? _______________________

What does your partner do? ____

When you are angry with your partner, what do you do? ___________________________

What does your partner do when angry with you? ________________________________

Do you enjoy being involved in activities separate from your partner? What do you like to do in those situations? ____

If your partner spends free time away from you, how at ease or stressed do you become?

____

____

Do you have relationships with other people that create conflict with your partner, and if so, why? ____

On a scale of 1 to 10, how aware or in touch with your emotions are you (1=not at all and 10=extremely)? ______ **Explain the rating you give yourself.** __________________________

On a scale of 1 to 10, how open are you in expressing your innermost feelings, desires, and thoughts to your partner (1=totally closed and 10=totally open)? _______ Explain the rating you give yourself. ____

What is the area or topic that it is most difficult for you to open with your partner about? Why? ____

How are your needs for connection and support met by your partner? __________________

____

____

When your partner wants support or encouragement from you, do you feel that you give it? How? ____

On a scale of 1 to 10, how committed to this relationship are you (1=not at all, 10= extremely)? _____ Explain the rating you give yourself. ______________________________

Have either of you threatened divorce, or to leave? _________________________________

On a scale of 1 to 10, how much do you still love your partner (1=not at all, 10=very deeply)? ____ Explain the rating you give yourself. ____

On a scale of 1 to 10, how much do you respect your partner (1=not at all, 10=very highly)? ____ What is it about your partner that creates that level of respect in you? _____________

____

Describe your sexual relationship. ____

What do you find most satisfying about it? What don't you like about it? How has your sexual relationship changed since you were first together? __________________________________

____

When do you feel most secure/safe in your relationship? ______________________________

When do you feel the most insecure? ____

What is your contribution to the problems in your relationship (i.e., your tendencies, actions which helped create or added to the difficulties between you two)? ____________________

____

If your relationship was a book or a movie, what would it be titled? And how would it end?

____