THE UNIVERSITY of MISSISSIPPI

Counselor Education Clinic for Outreach and Personal Enrichment

Adult Insurance and Consent Form

The Counselor Education Clinic for Outreach and Personal Enrichment (COPE) has been established to provide counseling services for children and families and individuals. Your counselor may be a licensed professional counselor or a graduate student counselor who is supervised by a licensed professional counselor.

Counseling involves sharing sensitive, personal, and private information that may be distressing at times. During the course of counseling, there may be periods of increased anxiety or confusion. The therapist is available for support through the entire counseling process. The outcome of counseling is generally positive; however, the level of satisfaction for any individual is not predictable.

All matters conducted at COPE are confidential and governed by the laws of HIPAA and the state of Mississippi. There are exceptions to confidentiality. If there is evidence of imminent danger or harm to yourself, your child, and/or others, a counselor is legally required to report this information to the appropriate authorities to insure the safety of everyone involved. Any case of suspected child abuse will be immediately reported to the department of human services, (DHS). We also must comply with any subpoenas received by a court of law. We may also release your protected health information in order to receive payment from insurance companies. Any disclosures other than the ones mentioned in this form will require a consent form signed by the parent or legal guardian.

The sessions will begin with an initial interview. The purpose of this interview is to determine your needs and to appoint a counselor. The fee for this interview is _____. A 45-minute counseling session is _____. Insurance forms will be filed at COPE. You will be responsible for any amount not covered by insurance. Your medical information will be released to your insurance company in order for your claim to be processed. Benefits will be paid to COPE.

Notes

i.e. – co-pay, deductible, secondary insurance etc.

_____

_____

_____

_____

_____

Your Information

Name:_____

Sex: M / F Marital Status: Single Married Other

Address:_____

City/State/Zip_____

Phone:_____

SSN:_____

DOB:_____

Insurance Company:_____

Policy/ID#:_____

Employer:_____

DX_____

Policyholder's information

Only complete this section if you are covered under someone else's policy i.e. spouse

Insured Name: _____

Sex: M / F Marital Status: Single Married Other

Address:_____

City/State/Zip_____

Phone:_____

SSN:_____

DOB:_____

Insurance Company:_____

Policy/ID#:_____

Employer:_____

By signing below I certify that the information provided by me in this document is true and correct. I agree to all the terms within this document and I have received a copy.

_____
Signature

_____
Date