FAMILY COUNSELING PLACE

Date of first session: Therapist:

PATIENT INFORMATION

Name _____ Home Phone (_____)_____

Address _____ Work Phone (_____)_____

City, State _____Zip_____ Cell Phone (_____)_____

Where may we leave messages? Home _____ Work _____ Cell _____ Do not leave messages _____

E-mail_____ May we send you email? Yes _____ No _____

Birth date *(include year)*_____ Sex: Male _____ Female _____

Whom may we thank for referring you?_____

Marital Status: Single_____ Married _____ Separated _____ Divorced _____ Widowed _____ Other_____

Employer or School Name _____

Name of Spouse _____ Birthdate *(include year)*_____

Years Married _____ Work Phone (_____)_____ Cell Phone (_____)_____

Spouse's Employer or School Name _____

Religious preference _____ Bishop/Pastor_____ Phone_____

List your present or previous health problems _____

List medications you are presently taking _____

Emergency Contact Name _____Phone_____

CHILDREN INFORMATION

Instructions: List all children. If any children are from a previous marriage, check the box before their name.

Name	Age	Concerns	Lives with you?

How did you find us? Referral ____ Google ____Yelp ____ Psychology Today ___Facebook____

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INSURANCE POLICY HOLDER INFORMATION

Name_____ SS# _____

Address _____ Home Phone _____

City, State, Zip _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Employer _____ Birth date *(include year)*_____

Relationship to Patient _____ Does patient have other insurance? Yes ____ No ___

Primary Insurance Company_____

Secondary Insurance Company_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby instruct and direct my insurance to pay Family Counseling Place directly for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. I authorize Family Counseling Place to release any medical records and/or office notes requested by my insurance company. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize Family Counseling Place to initiate and complain to the Insurance Commissioner for any reason on my behalf.

Signature _____ Date _____

RESPONSIBLE PARTY (If Other Than Insured Person)

Name _____ Home Phone (_____)_____

Address _____ Work Phone (_____)_____

City, State, Zip _____ Cell Phone (_____)_____

E-mail Address _____Relationship _____

I affirm that all information given is true and correct to the best of my knowledge.

Signature _____ Date _____

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Welcome to Family Counseling Place!

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is very important to our professional relationship. Please feel free to ask if you have any questions concerning our fees or financial policy.

Many clients prefer to schedule sessions in advance so as to be assured an appointment time that is convenient for them. We encourage this practice! It is ultimately your responsibility to make sure you are scheduled. For your convenience, you may schedule appointments through our website at www.familycounselingplace.com. Just click "Appointments." Easy-peasy!

_____If you cancel or miss an appointment and do not contact the office within 30 days, we understand that action to mean you are voluntarily terminating the clinical relationship.

Insurance/Financial Policy (please initial each paragraph signifying that you have read and understand)

_____Full payment by cash, check, or credit card is due at the time services are rendered unless prior arrangements have been made and approved by our office. We will accept your co-payment amount (rather than the full fee) only if we can verify that your deductible has already been met.

_____We will verify your benefits, but ***we are not liable for false or mistaken information given to us by your insurance company and we cannot guarantee payment of your claims.*** Ultimately, it is your responsibility to understand your insurance benefits. Filing insurance claims is a service provided as a courtesy to our clients. We do not file secondary insurance.

_____On occasion, a situation may arise which prevents you from keeping a scheduled appointment with your therapist. As a courtesy to your therapist, and ***to avoid a $75.00 "No Show" or "Late Cancellation" fee, please notify us at least 24 hours in advance*** if you cannot keep your appointment. This fee is not billable to your insurance company.

_____ If you have a credit balance of $5.00 or more, it will be refunded to you after insurance has made their final payment. Any "No Show" or "Late Cancellation" fees, write-off or discount amounts, or any other costs, will be deducted before a refund is made.

_____ A $20.00 fee will be charged for a returned check.

_____ In the event your counselor is **subpoenaed to make a deposition or testify in court**, the Fee will be $900.00 per day and is **due prior to** the court appearance.

Please fill in the following credit card information so that any balance over 90 days (whether personal or insurance) can be billed to your credit card:

Visa MasterCard Account Number: _____Security Code _____

Expiration Date: _____ Signature: _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account. I have read and understand this Statement of Understanding. I consent to receive treatment services from Family Counseling Place.

Signature_____ Date _____

Notice of Privacy Practices

1. **PURPOSE**: Family Counseling Place, its professional staff and employees, follow the privacy practices described in this notice. Family Counseling Place keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note, that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of Family Counseling Place may have access to your records.
2. **WHAT ARE TREATMENT AND HEALTHCARE OPERATIONS**? Your treatment includes sharing information among mental health care providers who are involved in your treatment. For example, if you are seeing both a physician (psychiatrist) and a psychotherapist, they may share information in the process of coordinating your care, with your signed permission. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of operations. Staff members may access clinical records periodically to verify that standards are met.
3. **HOW WILL FAMILY COUNSELING PLACE USE MY PROTECTED HEALTH INFORMATION**? Your personal mental health record will be retained by Family Counseling Place for a minimum of five years from the anniversary date of the date of the last treatment by the therapist. If the patient is younger than 18 years of age when last treated by the therapist, the medical records of the patient will be maintained by the therapist until the patient reaches age 21 or for seven years from the last treatment, whichever is longer. After that time has elapsed, the record will be shredded or burned or otherwise destroyed in a way that protects your privacy. Until the records are destroyed they may be used, unless you ask for restrictions on specific use or disclosure, for the following purposes:

    - Appointment reminders
    - Notification when an appointment is cancelled or rescheduled
    - For public health purposes such as reporting child or elder abuse or neglect; reporting reactions or medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree, or as required by law)
    - Mental health oversight activities, e.g., audits, inspections, or investigations of administration and management Family Counseling Place
    - Lawsuits and disputes (We will attempt to provide you advance notice of subpoena before disclosing information from your record)
    - Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victims of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred at Family Counseling Place; or when emergency circumstances occur relating to a crime
    - To prevent a serious threat to health or safety
    - To carry out treatment and healthcare operations and/or functions through medical transcription services
    - To military command authorities if you are a member of the armed forces or a member of a foreign military authority
    - National security and Intelligence activities
    - Protection of the President or authorized persons for foreign heads of state, or to conduct special investigations.
    - Alcohol and drug abuse information has special privacy protections. Family Counseling Place will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client's substance abuse situation unless: (i) the client consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personal need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

4. **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DICLOSURES-** Except as described previously, we will not use or disclose information from your records unless you authorize (permit) in

writing Family Counseling Place to do so. You may revoke your permission, which will be effective only after the date of your revocation.

5. **YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**-You have the following rights regarding your health information, provided you make a written request to invoke that right to Family Counseling Place:

   - Right to request a restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
   - Right to inspect and copy. You have the right to inspect and copy your mental health information regarding intake information, funding, payments, insurance claims, etc.; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional, chosen by Family Counseling Place. Family Counseling Place will comply with the outcome of the review.
   - Right to request clarified record. If you believe that the information we have about you is incorrect or incomplete, you may ask to add clarifying information. Family Counseling Place is not required to accept the information that you propose.
   - Right to accounting of disclosures. You may request an account of disclosures of your mental health information that have been made to person(s) or entities other than for treatment or health care operations in the last five (5) years, but not prior to April 14, 2003.
   - Right to a copy of this Notice. You may request a paper copy of this Notice at any time.

6. **REQUIRMENTS REGARDING THIS NOTICE:** Family Counseling Place is required to provide you with this Notice that governs our privacy practices. Family Counseling Place may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any other information we receive in the future. At any time you come in to Family Counseling Place for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.
7. **COMPLAINTS-** if you believe your privacy rights have been violated, you may file a complaint with Family Counseling Place, or with Gale Hartschuh, Office Administrator of Family Counseling Place. You will not be penalized or retaliated against in any way for making a complaint.

Contact*:* Call Family Counseling Place and ask to speak to Gale Hartschuh if:

- You have a complaint
- You have a question about this notice
- You wish to request restrictions on uses and disclosure for health care treatment or operations
- You wish to obtain a copy of this form to exercise your individual rights described above

Signature_____Date_____