Center for Counseling & Psychological Resources

Name:_____ Date: _____ S.S.N._____

D.O.B._____ Sex: ☐ Female ☐ Male Gender Identity: _____

Primary Language: _____ Translation Needed? ☐Yes ☐No

Parent/Guardian name (if minor): _____

Address:_____
Street City State Zip

Phone Number:_____ Email: _____

How would you like things to be different as a result of us meeting?_____
_____

How were you referred to CCPRLA? ☐*Word of Mouth* ☐*Internet* ☐*Other:*_____

Have you been in counseling before? ☐Yes ☐No Counselor: _____

When:_____How Long?_____ Previous Diagnosis: _____

Are you currently under a Physician's care? Yes/ No Name of Physician: _____

_____

Are you currently taking medication? Yes / No Prescriptions:_____

_____

Are you currently being treated for any medical conditions?_____

Do you have drug allergies? Yes/No If yes, please list. _____

_____

Person to Contact in case of Emergency:

Name: _____ Phone: _____Relationship: _____

Appointment Reminders

At the Center for Counseling & Psychological Resources, you can receive appointment reminders to your home phone, cell phone (by text), or to your email address the day before your scheduled appointment. Please complete the section below to receive reminders.

How would you like to receive appointment reminders? (check one)
☐ Via a text message on my cell phone (_____) _____
☐ Via an email message to the address listed above
☐ Via an automated telephone message to my home phone (_____) _____

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my rights to keep this information completely private, and requesting that it be handled as I have noted above.

Signature _____ Date _____

Center for Counseling & Psychological Resources

Financial Policies Statement of Understanding

Thank you for choosing The Center for Counseling & Psychological Resources to provide mental health care for you, your family member, or your family. We trust that your experience with our staff at all levels will be positive and helpful. Our staff consists of highly trained and qualified individuals committed to providing quality services to help you meet your mental health needs and expectations. Please recognize that you paying for these services is an important part of our treatment relationship. In order to help you understand your financial responsibilities, we have developed the following summary of our financial policies. Please read them, ask us about any policies that are unclear to you, and then sign the attached form to indicate your agreement. We thank you in advance for doing so.

Our help to you: As part of our services to you, our office routinely contacts your insurance company to determine your policy's mental health coverage. We will let you know what your benefits are. Unfortunately, they may be quite different from your coverage for physical illness. If your insurance benefit does not pay for services rendered, you are responsible for the remaining balance of the bill.

Forms: Before beginning treatment, you will be asked to provide important information about yourself by filling out all of our informational forms. Please let us know about any changes in this information as it occurs. You will be responsible for any changes not covered by your insurance company as a result of changes in your coverage not communicated to our Office Manager.

What you must pay: You are responsible for paying your portion of the fee for your service at the end of each session. If you are a "self-pay" client or have health insurance for which we are not a provider or do not accept. you are responsible for the full fee. If you have health insurance for which we are a provider and accept, you are responsible for your co-pay and any unpaid deductible amount. We will provide you a form that you will be able to submit to your insurance provider if requested.

Methods of payment: We accept payment by cash, credit/debit card and personal checks. There will be a charge of $40 for any returned personal checks.

Insurance: We will, in a timely manner, fill out and submit insurance forms for your primary and secondary insurance when we are a provider for that company or you have an out of network benefit. If your provider does not accept your benefit, you will be referred to another provider within our office or you may choose to be a "self-pay" client.

Late cancellations and missed sessions: We have reserved a special time for you and make every effort to meet with you at your scheduled time. We do not double or triple appointment times. Because it is not easy to fill appointment times at the last minute, we must charge you a late cancellation fee of $35.00 if you do not call to cancel 24 hours before your scheduled appointment. The late cancellation fee must be paid prior to scheduling your next appointment. Insurance companies do not pay for missed sessions.

Courtroom Testimony: Each clinician has set fees in their Declaration of Practice. You are required to place a $1,000.00 deposit prior to scheduling court/deposition with your clinician. If court date is continued/cancelled for any reason within 7 days of the scheduled date, the client will forfeit their entire retainer. If your court date is rescheduled 8 days in advance, you will be charged a 3 hour minimum.

Phone Calls/Emails/Text Messages: We do not charge for brief or infrequent phone calls, but if for some reason we need to have longer or more frequent communication, we will charge you at our usual rates by the quarter hour. Complicated issues are often best addressed during a scheduled office visit.

Balances due: We ask that you pay your part of your bill at the time services are rendered to you. From time to time you may, however, have a balance. When we bill you for this balance, we ask you to please pay it promptly. After 45 days with no payment or effort to arrange payment, our Office Manager will submit to medical collections.

Other Questions? We will happily answer any other questions you may have.

Please sign below and retain a copy of this form for your reference and return a copy of it to our office at your first visit.

I, _____ , have read The Center for Counseling & Psychological Resources Financial Policies Agreement and understand and agree to them.

I, _____ , give my permission for The Center for Counseling & Psychological Resources to disclose the minimum necessary health information in order to determine benefits and seek reimbursement from my insurance company for services rendered.

Signature: _____

Date: _____

Center for Counseling & Psychological Resources

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is required by the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and describes how mental health information about you may be used and disclosed and how you can get access to this information.

OUR PLEDGE REGARDING YOUR MENTAL HEALTH INFORMATION

Your mental health information is personal and we are committed to protecting it. We must create a file on you, which includes information about the services that we provide to you. This notice applies to all of the information in this file, your records, whether they are created by staff or your therapist.

This notice explains all of the ways in which we may use and disclose information in your records. *Use* refers to how information is shared among the staff of The Center for Counseling & Psychological Resources in order to make decisions about your treatment and care. *Disclosure* refers to how information is shared with or sent to others outside of this clinic. Please note that whenever we use or disclose your Protected Health Information (PHI), we only share the minimum necessary, except in special circumstances.

We are required by law to:

- Make sure that mental health information that identifies you is kept private,
- Give you a copy of this Notice of Privacy Practices regarding your mental health information, which explains our legal responsibilities, and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION

The following categories describe different ways that we may use and disclose mental health information about you. All of the ways in which we may use and disclose your mental health information will fall into one of these categories. However, not every use or disclosure will be described below.

After you have read this notice, you will be required to sign a consent form to allow us to use and disclose your PHI, as allowed by law. By signing the consent form, you are allowing us to use and disclose your PHI for Treatment, Payment, and Healthcare Operations (TPO). If you do not sign the consent form allowing us to use and disclose your mental health information for TPO, we will not be able to treat you. Any other uses or disclosures, beyond for TPO or when required by law, will require that you sign a separate authorization.

For Treatment

- We may use and disclose mental health information about you to provide you with mental health treatment or services.
- We may use and disclose mental health information about you to other The Center for Counseling & Psychological Resources staff and supervisors involved in providing you treatment or services.

For Payment

- We may use and disclose mental health information about you so that the treatment and services that you receive at The Center for Counseling & Psychological Resources can be billed to and payment may be collected from you, an insurance company, collection agency.

Appointment Reminders

- We may use and disclose mental health information about you to contact you as a reminder of your appointments or to reschedule your appointments.

As Required by Law

- We will disclose mental health information about you when required to do so by federal, state, or local law. Please note that we are required by law to report any suspected child abuse, elder abuse, or abuse of a dependent adult.

To Avert a Serious Threat to Health or Safety

- We may use and disclose mental health information about you when necessary to prevent a serious threat to your health or safety, or to prevent a serious threat to the health or safety of another. Examples of this may be you expressing suicidal intent or homicidal intent. In such a case, we will only disclose information to someone who is able to assist in preventing harm to you or to others.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with The Center for Counseling & Psychological Resources. To file a complaint with The Center for Counseling & Psychological Resources, please contact Jill Waltemate at info@ccprla.org. Please note that all complaints must be submitted in writing.

Print Signature /Date

Center for Counseling & Psychological Resources

"Clinic Policies Statement of Understanding"

CONFIDENTIALITY AND PRIVACY:

Patient confidentiality will be respected at all levels of communication and is protected by Federal and State Laws. There are, however, situations in which confidentiality may be compromised by the provider's professional and legal duty to protect. Briefly, these situations may include a strong indication of imminent danger to self or others or indication of abuse or neglect of another. Patients under the age of 18 require a parent or legal guardian to receive services. Please discuss your concerns about the limits of confidentiality with your provider and read the HIPAA privacy statements provided in your intake paper work.

EMERGENCIES/CRISIS SITUATIONS:

Our office is a multi-specialty counseling center. We provide evaluations and treatment for adults, adolescents and children. We are not designed to be an acute care clinic or a crisis center. If you or a family member is in immediate crisis, this is how our clinic handles crisis situations to ensure your safety:

1. The patient may be seen for an emergency session if they are not presenting with active threats of harm to self or others.
2. If a potential or active patient calls our office and reports being at high risk (current thoughts of suicide or thoughts of harm/violence to others), office staff will direct them to the local emergency room or 911. We do not accept actively suicidal or actively violent clients, as we are not the highest level of care for these situations.
3. If a potential or current patient refuses to voluntarily admit himself or herself to the local ER/inpatient facility or call 911 for their immediate safety, our office staff will call the police and report the risk to local police to ensure safety.

RELEASE OF INFORMATION:

Following the execution of a valid Patient Authorization Form (Release of Information), patient records or a treatment summary will be forwarded to a licensed professional. Requests to obtain a personal copy of your medical chart and requests to release records to any other entity (including attorneys) will be reviewed on an individual basis. This service is billed at the actual cost of supplying the records, and includes cost of copying, mailing, and professional time. Any request for release of records must be allowed at least two weeks of preparation time.

FEES, PAYMENTS & INSURANCE:

Payment is due at the time of service. For your convenience we accept cash, money orders, all major credit/debit cards, and personal checks. If your check is returned from your financial institution, we will no longer be able to accept them. You will be subject to a $40 service charge and in the future will be required to pay with either cash or a credit/debit card.

Our Staff is here if you need us, please don't hesitate to let us know if you have questions or concerns of any kind. We look forward to working with you and your family.

_____ _____

Print Name Signature and Date