Client Information

Client Name: _____ Gender: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate number: _____Email address: _____

Emergency Contact: _____ Relationship: _____Phone Number: _____

Insurance Information

Insurance Company: _____ Phone Number: _____

ID # _____Group # _____ Policy # _____

Effective Date: _____ Copay/ deductible: _____

Policy Holder Information

Name: _____ Date of Birth: _____

Relation to Client: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Phone Number: _____

ID # _____Group # _____ Policy # _____

Effective Date: _____ Copay/ deductible: _____

I assign all benefits from insurance or other third-party coverage to the provider of service. I understand that by signing this form, I acknowledge that if my insurance carrier or I-IB/IO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by a provider.

Client Signature: _____ Date: _____

Financial Agreement and Authorization to Charge Credit Card

Co-payments are due at the time of service. Insurance policies are contracts between you and your insurance company. I file these claims as a courtesy and try to help with problems, but you may need to resolve those beyond my control. You will be charged for any insurance claims that are not paid. If I am not covered by your insurance company, full payment is due when services are provided. Phone conversations are not covered by insurance and are charged at a prorated fee based on $125/ hour. Any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time will be charged a fee of $125.00. This is not covered by your insurance company.

You are discouraged from requesting my participation in legal proceedings. If you become involved in legal proceedings and do request my participation, you will be expected to pay for all of my professional time, including preparation and/or transportation costs, even if I am called to testify by another party. The rate for this participation is $300 per hour, including preparation time, time away from my office, and all related correspondence with third parties, with a retainer fee of $1500 due in advance. You also acknowledge that any testimony may not be in your favor, as I can only testify to facts and professional opinion.

If you request a written letter, treatment summary, etc., you will be charged a prorated fee based on $125 per hour, with a minimum fee of $25 per document. If you request your records, you will be charged the associated fees per the PA State Code for Medical Records Charges. I authorize Heal Yourself Counseling to submit claims for psychotherapy sessions to the insurance policy that I have presented.

I authorize Heal Yourself Counseling to charge the card provided on this Financial agreement for co-payments, coinsurance, deductibles. full session fee if self-pay, and for late cancellations or no-shows. You may change this authorization at any time by providing a written statement to the practice. All transactions will be documented and available upon request. I understand that if my credit card does not accept a charge, I will immediately make the payment to the practice. I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owed will be due & paid in full. I acknowledge that credit card transactions could be linked to Protected Health Information.

Credit Card Information:

Name (as it appears on your card):

Card):

16-digit card number:

Expiration date:

Card type (Visa, Mastercard, Flex Spending

3-digit CVV Code (located on the back of your card: Zip code:

Client Signature: _____ Date: _____

No-Show/ Late Cancellation Policy

This policy has been established to provide the highest level of care to all clients who receive care from Heal Yourself Counseling. It has been proven that consistent attendance provides the greatest opportunity for success. By providing notice of a cancellation, I may be able to accommodate other clients with your appointment slot. I would like to remind you of my office's policy regarding missed appointments.

Clients must call 24-hours prior to their scheduled appointment time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of your appointment will be considered a late cancellation. I do understand that emergencies arise and that it may not be possible to give such a notice. Any potential exceptions to the No-Show/Late Cancellation policy will be determined by the provider.

Clients should plan to attend on time for scheduled appointments. I will allow a 10-minute grace period for 50–60-minute appointments. Beyond the grace period listed, your provider reserves the right to cancel your appointment and charge a late fee, Fees for No-Shows or Late Cancellations are as follows:

Psychotherapy

- Missed Intake or Follow-up appointments: $125

Continuation of Services

- Heal Yourself Counseling reserves the right to discontinue services after THREE No-Show/or Late Cancellations. A No-Show and/or Late Cancellation for an appointment will be included in determination of ongoing care.
- If extenuating circumstances have contributed to missed appointments, all clients have the right to appeal the discontinuation of services by writing a letter explaining such circumstances.

Thank you for providing my practice and other clients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

_____ _____

Signature of Client Date

Consent for Release of Information

This authorizes Heal Yourself Counseling to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____Therapist: _____

This will authorize Heal Yourself Counseling to release to/obtain from:

Name: _____

Relationship to Client_____

Address: _____City: _____State: _____ Zip: _____

Phone: _____Fax:_____

Information from the medical record maintained from (please list dates such as "all", or 1/21 to 6/21):_____

The information to be disclosed is (please check all info that you are willing to have exchanged):

____History and intake information

____Social/ Psychological/ Medical reports

____Chemical dependency abuse or diagnosis, history and

____Progress reports

____Treatment plan, goals, and results

____Medications used in treatment

____Other (specify)

The purpose of the information release is (please check all that apply):

____Diagnosis and evaluation

____To facilitate treatment

____Treatment planning

____Other (specify)

If we are requesting the Authorization from you for our use and disclosure or to allow another health care professional or entity to disclose information: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) We must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time. This authorization lasts for one year after the date you sign it unless you enter a different date of expiration here:_____

By signing this authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client_____ Date_____

Consent for Telehealth Consultation

1. I understand that my health care provider wishes me to engage in a telehealth consultation.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY A HIPAA COMPLIANT PLATFORM

Telehealth by HIPAA compliant platform is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, Telehealth Service will not be used to provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth, HIPAA compliant service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.

4. I do not assume that my provider has access to any or all the technical information in the Telehealth, HIPAA compliant platform service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the Telehealth, HIPAA compliant platform service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me.

• That I fully understand its contents including the risks and benefits of the procedure(s).

• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Signature: _____ Date: _____

Crisis Coverage

If you are in a life-threatening crisis, please go to the nearest emergency department or call 911 no matter what time of day it is. If you are in crisis, please call:

Call Lifeline at (800) 273-8255 (National Suicide Prevention/Crisis Lifeline)

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call 911

- Call Lifeline at (800) 273-8255 (National Suicide Prevention/Crisis Lifeline)

- Go to the emergency room of your choice

Emergency procedures specific to Telehealth services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your Emergency Contact Person here:

ECP (Emergency Contact person): _____ Phone: _____

You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list this hospital and contact number here:

Hospital: _____ Phone: _____

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list this police department and contact number here:

Police Department: _____ Phone: _____

Confidentiality

What you share in session is CONFIDENTIAL and will only be discussed with other people with your written permission.

There are 5 situations where confidentiality can be broken without your written permission.

These situations include:

1. Medical Emergencies

2. Under court order or requirement of law

3. If the practitioner believes that the client is in serious danger of hurting themselves or others

4. If a vulnerable adult or child reports abuse. Practitioners are mandated reporters.

Cancellation Policy: or changes of an appointment must be made at least 24 hours in advance, or you are charged for your session. Please note that insurance companies do not pay for canceled appointments. This is standard practice and is intended in part to preserve the time for those who may need it.

Fees, Phone Calls and Reports: $125 for the initial diagnostic session; $125 for individual sessions. Full payment (or co-payment if services are covered by insurance and any deductible has been satisfied) is due at the beginning of the therapy hour. No show/cancellations made with less than 24-hour notice will be charged at $125. Please note: All payment, including co-pays/co-insurance, late or cancel appointment fees, and unpaid claims from your insurance company is due prior to or at the time of service or your appointment your client account balance is overdue or there is no payment plan in place for your outstanding balance, I reserve the right to reschedule your appointment until payment or payment plan agreement is received.

Insurance and Bookkeeping: In many cases, insurance companies provide outpatient mental health benefits to their insured customers. Please remember that services are provided for and charged to you, not to your insurance company. You are responsible for checking with your insurance company and/or your employer to be certain that they cover the services provided. As a courtesy, I will check insurance coverage, but I cannot guarantee that they will ultimately provide coverage for your services or that the information provided to me when trying to verify your coverage will be accurate. There are a wide variety of insurance plans available per company; a guarantee cannot be made that any particular company will provide payment for services that you receive due to this. If your insurance company does not cover the services you receive, you are fully responsible for the amount due. If you have any questions about obtaining coverage, please ask.

Past Due Balances: Should you have a past due balance after 30 days, you will receive an initial statement informing you of this with a past due stamp. If your balance is 60 days past due, you will receive a second notice, and your provider may reach out to you personally to get the issue resolved. You will also receive a notice that after 90 days you will receive a finance charge should you not take care of the balance immediately. At 90 days past due, I will send your information and balance to collections, and you will be terminated as a client from Heal Yourself Counseling. I will provide you with appropriate referrals for your continued care.

Collections: In case you do not pay your bill, Heal Yourself Counseling reserves the right to seek payment with a collection agency or through other legal means. The cost of collection may be added to your bill.

Notice of Health Information Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Heal Yourself Counseling is committed to handling and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal information collected, how and when it is used, and how it might be disclosed. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information :

Each time you visit Heal Yourself Counseling, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your professional record, serves as a:

● Basis for planning your care and treatment

● Means of communication among the many health professionals who contribute to your care

● Legal document describing the care you received

● Means by which you or a third-party payer can verify that services billed were actually provided

● A source of information for public health officials charged with improving the health of this state and the nation

● A tool to assess and continually work to improve the services rendered and the outcomes Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights :

Although your health record is the physical property of Heal Yourself Counseling, the information belongs to you. You have the right to:

● Obtain a paper copy of this notice of information practices upon request

● Inspect and copy your health record as provided for in 45 CFR 164.524

● Amend your health record as provided in 45 CFR 164.528

● Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528

● Request communications of your health information by alternative means or at alternative locations

● Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522

● Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Responsibilities of Heal Yourself Counseling:

Heal Yourself Counseling is required to:

● Maintain the privacy of your health information

● Provide you with this notice of legal duties and privacy practices with respect to information collected and maintain about you

● Abide by the terms of this notice

● Notify you if practitioner is unable to agree to a requested restriction

● Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

Heal Yourself Counseling reserves the right to change the practices and to make the new provisions effective for all protected health information. Should any information practices change, you will be given a revised notice.

Heal Yourself Counseling will not use or disclose your health information without your authorization, except as described in this notice. Heal Yourself Counseling will also discontinue using or disclosing your health information after receipt of a written revocation of the authorization according to the procedures included in the authorization.

Client Responsibilities

Each client has the responsibility to:

• Refrain from physical (and other) abuse of self, others, and property.

• Pay balances and/or copays on time.

• Refrain from the use of a mood-altering substance prior to receiving services at Heal Yourself Counseling. If it is suspected that you are under the influence of a mood-altering substance, Heal Yourself Counseling reserves the right to cancel your appointment and charge a late cancellation fee.

• Arrive on time to scheduled appointments. Should you arrive 10 minutes late for a 50–60-minute appointment, your provider reserves the right to cancel your appointment and charge a late cancellation fee.

• Devote reasonable energy and time to therapy work. Therapy is generally “hard (emotional) work”. For progress to occur, it is recommended to view your therapy a high priority in your personal life. Homework may be assigned to help you learn about yourself.

• Fulfill contracted behavior.

• Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.

• Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions can apply for emergencies and other extenuating circumstances.

• Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider. Verification can be through the billing coordinator, who will contact your insurance company to check your benefit status upon request.

• Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.

Adult Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

__ I have no problem or concern bringing me here

__ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals

__ Aggression, violence

__ Alcohol use

__ Anger, hostility, arguing, irritability

__ Anxiety, nervousness

__ Attention, concentration, distractibility

__ Career concerns, goals, and choices

__ Childhood issues (your own childhood)

__ Codependence

__ Confusion

__ Compulsions

__ Custody of children

__ Decision making, indecision, mixed feelings, putting off decisions

__ Delusions (false ideas)

__ Dependence

__ Depression, low mood, sadness, crying

__ Divorce, separation

__ Drug use—prescription medications,

over-the-counter medications, street drugs

__ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")

__ Emptiness

__ Failure

__ Fatigue, tiredness, low energy

__ Fears, phobias

__ Financial or money troubles, debt, impulsive spending, low income

__ Friendships

__ Gambling

__ Grieving, mourning, deaths, losses, divorce

__ Guilt

__ Headaches, other kinds of pains

__ Health, illness, medical concerns, physical problems

__ Housework/chores—quality, schedules, sharing duties

__ Inferiority feelings

__ Interpersonal conflicts

__ Impulsiveness, loss of control, outbursts

__ Irresponsibility

__ Judgment problems, risk taking

__ Legal matters, charges, suits

__ Loneliness

__ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments

__ Memory problems

__ Menstrual problems, PMS, menopause

__ Mood swings

__ Motivation, laziness

__ Nervousness, tension

__ Obsessions, compulsions (thoughts or actions that repeat themselves)

__ Oversensitivity to rejection

__ Pain, chronic

__ Panic or anxiety attacks

__ Parenting, child management, single parenthood

__ Perfectionism

__ Pessimism

__ Procrastination, work inhibitions, laziness

__ Relationship problems (with friends, with relatives, or at work)

__ School/College problems

__ Self-centeredness

__ Self-esteem

__ Self-neglect, poor self-care

__ Sexual issues, dysfunctions, conflicts, desire differences

__ Shyness, oversensitivity to criticism

__ Sleep problems—too much, too little, insomnia, nightmares

__ Smoking and tobacco use

__ Spiritual, religious, moral, ethical issues

__ Stress, relaxation, stress management, stress disorders, tension

__ Suspiciousness, distrust

__ Suicidal thoughts

__ Temper problems, self-control, low frustration tolerance

__ Thought disorganization and confusion

__ Threats, violence

__ Weight and diet issues

__ Withdrawal, isolating

__ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

__ Other concerns or issues:

Client Receipt of Information

I have read, understand, and agree to abide by the policies given to me in the Client Registration and Treatment Contract Handbook. I understand all information provided to me within these documents; should I have concerns about any policies, I will discuss them with my therapist. The information I received includes.

Client registration

No-Show/ Late Cancellation Policy

Consent for Release of Information

Consent for Telehealth Consultation

Crisis Coverage

Confidentiality

Notice of Health Information and Privacy Practices

Adult Checklist of Concerns

_____ _____

Signature of Client Date