Bringing Hope Counseling

Welcome! Thank you for choosing Bringing Hope Counseling (BHC). BHC has a great passion for living life to the fullest and a strong desire to support you in gaining a healthier and more hope-filled life.

INITIAL APPOINTMENT: The following paperwork MUST be filled out prior to your appointment.

APPOINTMENTS

Based on your treatment goals, you will be attending outpatient services with a qualified therapist. These appointments are 30 – 60 minutes in length. The duration and frequency of your appointments will be reflective of your individualized need. **If you are more than 15 minutes late for ANY appointment you may be asked to reschedule your appointment as providers are typically scheduled with appointments ALL DAY and cannot delay the treatment of other clients.**

NO SHOW/CANCELLATION POLICY

Due to our availability, it is important to keep your appointments with your provider. We do understand life is often busy and other obligations come up. For commercial insurance clients: Our policy allows for ONE NO-SHOW appointment per calendar year. However, after the second No Show appointment (does not have to be consecutive), there is a $25 fee that is to be paid prior to the next appointment. For Medicaid clients: you will be allowed to reschedule after the first No-Show. However, after the second No-Show you will have to call in each day to see if there are available slots for that day. We request at least 24 hour notice for cancellations. After 60 days of inactivity, you will receive a closure letter letting you know that your chart will be closed unless you decide to re-engage in counseling within 14 days of the closure letter.

BILLING AND PAYMENT REQUIREMENTS

BHC accepts payments from many commercial insurance companies. It is your responsibility to pay any amount not covered by your insurance company. Cash rates are also available which may be paid by cash, check or credit card. There will be a $25 fee for all returned checks. If more than one check is returned, all future payments MUST be made by cash, credit card, or money order. Please note that there may be other services that you require/request that are not covered by insurance and will be your responsibility to pay. These may include, but are not limited to - records request, report writing, letter writing, court appearances, etc. (Charge sheet attached.)

RISKS/BENEFITS TO THERAPY

Therapy can cause feelings to be surfaced that may have been repressed for a long time. This can often be painful and challenging. The therapist will support you through this and provide you with skills to learn to cope with these feelings. Often times, things may get worse before they get better. The reason for this pattern is as we begin to deal and address painful areas in our life, difficult feelings are experienced. It may feel like these areas are best left unaddressed. However, the benefits of therapy and addressing these issues are greater in the end. To learn to face these challenges, gives you strength and frees you to engage in your own life in an "awakened" state versus feeling "numb".

Bringing Hope Counseling

Client's Rights

1. I have the right to decide not to enter therapy with Bringing Hope Counseling (BHC). If I wish names of other therapists will be provided.

2. I have the right to end therapy at any time. The only thing I will have to do is to pay for any treatments I have already had. I may, of course, have problems with other people or agencies if I end therapy – for example if I were sent to therapy by the courts.

3. I have the right to ask any questions, at any time, about what we do during therapy and to receive answers that satisfy me. If I wish, each method will be explained to me.

4. I have the right not to allow the use of any therapy technique. Upon my request the benefits and risk of each technique will be shared.

5. I have the right to keep what I tell staff private. Generally, no one will learn of our work without my written permission. There are some situations to which BHC is required by law to reveal some of the things I report, even without my permission, and if BHC does reveal these things BHC is not required by law to tell me that it was done so. Here are some of these situations:
   a. If I seriously threaten to harm another person, BHC must warn that person and the authorities.
   b. If a court orders BHC to testify about me, BHC must do so.
   c. If BHC is testing or treating me under a court order, BHC must report finding to the court.
   d. If I threaten to harm myself, BHC must contact the proper authorities or family member to protect client.

6. I have the right to review my records in my file at any time, upon written request. If I disagree with anything documented in my records, I have the right to amend (not delete) my records.

7. Minors and parents: Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, your therapist will provide them with only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Your therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless your therapist feels that the child is in danger or a danger to someone else. In which case, your therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections he/she may have.

Bringing Hope Counseling

CONSENT TO TREAT & CLIENT ORIENTATION

(Please initial beside each space.)

_____ We/I agree to allow Bringing Hope Counseling (BHC) to provide services to myself/our family. We/I understand that we/I may choose another provider for this service and we/I have freely chosen to work with BHC.

_____ The goals of therapy have been/will be explained and we/I will participate in developing a treatment plan, which will identify goals that we/I will work towards, including specific time frames and objectives needed to accomplish the goals.

We/I understand that purpose for and have completed the following or received the following information:

_____ Client Rights

_____ HIPPA

_____ Client Orientation

_____ Financial Contract/Payment Agreement

_____ Release of information

_____ _____

Client/Guardian's Signature Date

_____ _____

Staff Signature Date

Bringing Hope Counseling

Privacy Notice (HIPPA) Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information maintained here at Bringing Hope Counseling (BHC). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow up with the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have been informed by BHC of my right to privacy and obtained a copy of the Privacy Notice which contains a more complete description of the possible uses and disclosure of my health information. I was given the right to review the Privacy Notice prior to signing this consent form. I understand that BHC has the right to change its Privacy Notice at any time and that I may contact the organization at any time in order to obtain a current copy of the Privacy Notice.

I also understand that if I need more or have questions, I may contact BHC at the number listed on the Privacy Notice.

4

I understand that I may request in writing that BHC restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that BHC is not required to agree to my requested restrictions, but if BHC agrees to my restrictions, then the organization is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that BHC has taken action relying on this content.

_____ _____

Client/Guardian's Signature Date

_____ _____

Staff Signature Date

Bringing Hope Counseling

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
INDIVIDUAL/AGENCY

Client Name: _____ DOB: _____

Address: _____

I, the undersigned, hereby authorize a two-way authorization for the release of the following information between Bringing Hope Counseling (BHC) and the individual/agency(ies) indicated.

Information to be released (check all that apply):

- o Master Treatment Plan
- o Medical Records
- o Written/Verbal Communication
- o Other

Name and address of Individual/Agency you wish to authorize information to:

1. _____

2. _____

5

3. _____

I understand that this authorization/release will remain in effect for 1 year unless specifically stated otherwise below and/or I specifically revoke it by notifying BHC before the release of the above information.

- o For 180 days
- o Until _____(Specify Date)

_____ _____
Client Signature Date

_____ _____
Printed Name Witness/Date

_____ _____
Signature of legal guardian/Relationship Date

Bringing Hope Counseling

Medication Record

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x a day)	Time	AM / PM

Bringing Hope Counseling

PATIENT REGISTRATION AND FINANCIAL AGREEMENT

Name: _____ Date of Birth: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State_____ Zip: _____

Phone: _____ May we leave a message at this number? Y or N

Email: _____ Social Security Number: _____ Sex: M or F

Employer: _____ Employer phone: _____

Emergency Contact: _____ Phone: _____

Financial/Insurance Information: Please allow us to make copies of all of your insurance cards as well as your driver's license. The following information is necessary to process insurance claims:

Primary Insurance: _____ Policy Holder's Name: _____

7

Date of Birth: _____ ID # and Group #: _____

Secondary Insurance: _____ Policy Holder's Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize the release of any medical information necessary to process my claims. I hereby authorize Bringing Hope Counseling (BHC) to apply for benefits for services rendered by them. I request that payment from my insurance company be made directly to BHC. I permit a copy of the authorization to be used in place of the original. My insurance company or I may revoke this authorization at any time. This revocation must be submitted to BHC in writing.

I am responsible for all copays/coinsurances, which are due and payable at the time services are rendered, as well as deductible amounts. If, for some reason, insurance denies my claims, I am responsible for these balances as well. If further action ever becomes necessary and is taken in order to collect any delinquent balance due on my account, I agree to pay for all collection, attorney, and court fees incurred by BHC for the collection of any and all balances due on my account. I am aware that 1.5% interest is assessed on all account balances each month.

By signing below, I acknowledge: I have read and understand the preceding statements regarding my insurance, as well as my financial responsibilities, including if insurance does not pay. I am responsible for any outstanding balance on my account.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Bringing Hope Counseling (BHC) Consent for Telebehavioral Health

Introduction of Telebehavioral Health:

As a client or patient receiving behavioral health services through BHC, I understand:

Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

I also understand that my insurance may not cover telehealth services, and I should contact my insurance company to verify coverage for behavioral health teletherapy. If this is not a covered service, and I still choose to participate, I will be financially responsible for this service.

Software Security Protocols:

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Exchange of Information:

The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

During my telebehavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:

If a need for direct in-person services arises, it is my responsibility to contact a practitioner in my area, to contact my behavioral health practitioner's office for an in-person appointment, contact my primary care physician if my behavioral health practitioner is unavailable, or call 911 if I am in danger of harm to self or others.

Self-Termination:

I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology:

These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed. This is currently being offered as a temporary service due to COVID-19.

Emergency Protocol:

In emergencies, my therapist may feel it necessary to contact my designated emergency contact person. I have designated the following person as my emergency contact person:

Name: _____

Relationship: _____

Phone: _____

Disruption of Service:

In the event of disruption of service, it may be necessary to communicate by other means. If there is disruption of service, I understand that my therapist may attempt to contact me by phone to complete the remainder of the session. If contact cannot be made by this method, I understand that my session may be terminated and I will only be billed for the time spent with my provider.

Communication:

It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

Laws & Standards:

The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Confirmation of Agreement:

_____

Client Printed Name

_____ **Date:** _____

Signature of Client or Legal Guardian

_____ **Date:** _____

Printed Name of Practitioner

_____ **Date:** _____

Signature of Practitioner

Bringing Hope Counseling LLC
Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVC Code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize **Bringing Hope Counseling LLC** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date