Positive Mind Counseling, LLC

Demographics Information

Date:_____

CLIENT INFORMATION:

Client's Legal Name:_____ Client Preferred Name:_____

Date of Birth:_____ Age:_____ Marital Status:_____ Social Security Number:_____

Home Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Preferred Contact: Home / Cell / Work / Email / Text

Employment Status: FT / PT / Retired / Unemployed Employer:_____

Primary Care Physician & Phone Number:_____

Prescribing Psychiatrist & Phone Number:_____

****If client is under age 18 please complete following section****

Guardian Name:_____

Guardian Home Address: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Preferred Contact: Home / Cell / Work / Email / Text

Name of Attending School & Grade:_____

****Emergency Contact Information****

Name:_____ Relationship:_____

Home Address:_____ Phone Number:_____

HEALTH INSURANCE INFORMATION

Name of Insurance Company:_____ Insurance Company Phone Number:_____

Policy Number:_____ Group Number:_____

Policyholder (self, spouse, parent, etc.):_____ DOB:_____

Policyholder's Address:_____ Policyholder Employer:_____

Additional Health Insurance:_____

Deductible:_____ Copay:_____

Positive Mind Counseling, LLC

Informed Consent to Treatment & Disclosure

Thank you for selecting Positive Mind Counseling to support you in reaching your goals! In order to best assist you it is important you read and understand this document in its entirety. A therapeutic relationship between a person and a therapist works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand, as well as legal limitations to these rights that you should be aware of. Please take your time reading through this information and **INITIAL IN SPACES PROVIDED**. If you have any questions about any of our policies, please feel free to ask.

_____Risk/Benefits of Counseling: While there are no guarantees to specific outcomes, making the decision to engage in counseling provides an opportunity to make positive changes to your life. These changes may include, but are not limited to, increased satisfaction in relationships, increased ability to cope with stress, better understanding of your own wants/needs, improved communication, overall better moods, decreased anxiety, and increased self-esteem, as well as replacing maladaptive behaviors with healthier more productive ones. In order to experience the changes you want to see, you may be faced with challenging and uncomfortable feelings, at times, throughout the process. These may include, but are not limited to, intense negative emotions related to trauma, changes in relationships that were not intended, and uncertainty about yourself. Additional risks may include, but are not limited to, denial of health insurance coverage due to diagnosis or treatment of "pre-existing conditions."

_____Confidentiality: (please refer to HIPAA Notice of Privacy Practices for further details). Based on the law and professional ethics, all clients have the right to confidentiality and privileged communication about specific information shared in session. Positive Mind Counseling, LLC, is in compliance with federal and state laws and will maintain the privacy of your PHI (protected health information). If you request to have your PHI released or obtained to/from anyone outside of Positive Mind Counseling, LLC, you will be required to sign a release of information prior to information being shared or received.

While confidentiality is a right, there are limitations surrounding confidentiality you should be made aware of as listed in the following:

*Your therapist at Positive Mind Counseling, LCC may consult with other professional colleagues in order to provide you with the best care. This is considered best practice for therapists in private practice. During any type of clinical supervision or consultation, no identifying information about you (i.e., your name) will be used.

*If it is determined that at any time you pose an imminent risk to yourself or others, Positive Mind Counseling, LLC is required by law to release necessary information to the appropriate parties to ensure safety.

*Abuse/Neglect: In the event of reported or suspected abuse and/or neglect of children, or vulnerable adults (i.e., elder abuse, disabled persons), Positive Mind Counseling, LCC is required by law to report this information to the appropriate authorities. Additionally, any suspected or reported animal abuse will also be reported to appropriate authorities.

* If you are a minor child, your parent/guardian has the right to receive updates on your progress in treatment, however, they will not be given specific details of in session conversations.

____Confidentiality & Technology: You may choose to use various technologies as part of your treatment experience, including email, texts, voicemail, and fax. Positive Mind Counseling, LLC will take every precaution to safeguard your information, but cannot guarantee that unauthorized access to electronic communication could occur. Please be aware of this when choosing to utilize these forms of communication. It is recommended that only non-clinical issues (i.e., scheduling, billing, cancellations, etc..) be communicated using email or text, this will help to ensure confidentiality.

____**Social Media Policy:** Therapists at Positive Mind Counseling, LLC will not accept or respond to any friend/follow requests from current or former clients on any social networking sites, as this compromises confidentiality and blurs the boundaries of our professional relationship.

____**Insurance:** If you have a health insurance policy, it is likely you have some mental health coverage. With your consent, Positive Mind Counseling, LLC will assist you in obtaining information relevant to your coverage and billing for sessions provided, however**, it is your responsibility to be informed of the scope of your coverage by calling your insurance company and ensuring that you understand your benefits.** Additionally, while you are in treatment it is your responsibility to inform Positive Mind Counseling, LLC of any changes to your insurance coverage. Please note insurance companies require you to authorize Positive Mind Counseling, LLC to provide them with protected health information such as diagnosis, dates of services, and possibly your treatment plan in order to secure payment. If your policy requires you to cover a percentage of the session fee (i.e., copay), the amount due is to be paid at the time of the session in full by cash, check or credit card. Furthermore, some insurance plans have a deductible, this is the out-of-pocket amount that must be paid by the patient prior to insurance companies being willing to cover any portion of the service fee. Finally, if you use your insurance plan, authorization from your insurance company may be required prior to your intake appointment before they will cover therapy sessions. If you did not obtain prior authorization and it is required, you will be responsible for full payment of the session fee that was not covered by insurance due to lack of authorization.

____**Appointments:** Initial assessments will be 60 minutes in duration, and subsequent appointments will typically be between 45-55 minutes dependent on insurance coverage. To begin, sessions are typically scheduled on a weekly basis, however, this is determined based on your identified needs, clinical recommendations, and availability. The time scheduled for your therapy session is reserved for you. Therefore, if you need to cancel or reschedule a session, you are asked to provide at least 24 hours' notice. You are responsible for arriving to your therapy session on time, if you arrive late, your appointment will still need to end at the originally scheduled time.

____**Attendance:** Consistent attendance in therapy greatly contributes to a successful outcome. If you need to cancel or reschedule a session with your therapist, you are expected to contact your therapist directly with a 24 hour notice. If you miss a session or cancel without a 24 hour notice, you will be subject to a cancellation/missed appointment fee of $75, unless we both agree you were unable to attend due to circumstances beyond your control. Please be advised this fee is not covered by insurance and cannot be paid through a HSA/FSA account; you are responsible for this fee. Additionally, if you are a no show or late cancellation for 3 sessions within a 60 day period, you will likely be discharged from services at Positive Mind Counseling, LLC. If at any time during your treatment, it becomes apparent that consistent attendance in therapy is a concern, you or your therapist can initiate a discussion about this in order to best address the concern.

____**Crisis/Emergency:** Positive Mind Counseling, LLC and its' therapists are not available 24 hours a day. If your call is not immediately answered, it is because they are with clients or otherwise unavailable. You are welcome to leave a message on the confidential voicemail and your call will be returned as soon as possible. If you are experiencing a behavioral health crisis, please call 911 or, if safely able to, get to your nearest hospital emergency room, rather than leaving a voicemail. This will help ensure you get the treatment and support you need as quickly as possible.

____**Notice of Privacy Practices**: I have received, read, and understand Positive Mind Counseling, LLC Notice of Privacy Practices.

_____

Client Name Printed

_____ _____

Client or Parent/Guardian Signature Date

Positive Mind Counseling, LLC

Financial Agreement

____If you choose to utilize your insurance benefits Positive Mind Counseling will make an effort to verify your insurance benefits, however, you are ultimately responsible for contacting your insurance company to ensure that you are aware of all benefits, copays, pre-authorizations, deductibles, and out of network provider guidelines.

____Co-pays and/or session fees are due at the time of service, and can be paid by cash, check, or credit card. Outstanding balances cannot extend past 2 sessions and no further sessions will be scheduled until balance is paid. If an outstanding balance extends past 2 sessions and arrangements for payment have not been made with your therapist, your credit card on file will be charged.

____ If you choose to self-pay for sessions, payment is due at the time of service and can be paid via cash, check, or credit card.

____You are responsible for any outstanding balances not covered by your insurance policy, including but not limited to deductibles, denials and cancelled coverage. Balances are expected to be paid in full within 30days and will be charged to your credit card on file unless other payment arrangements have been made with your therapist.

____If you request your therapist to attend an outside meeting on your behalf (i.e., school meetings, DCF meetings, etc.) there will be a $75 charge per hour. A $75 deposit is expected to be paid prior to the meeting date.

____ If your therapist should receive a subpoena to appear in court on your behalf there is a $500 charge per hour, including travel time, and time spent in court. A deposit of $1000 will be required prior to court date.

____There is a $30 service fee for all returned checks.

____**Cancellation Policy:** As stated in the Informed Consent, there is potential for a $75 fee for appointments cancelled without 24 hours' notice. You will be given the option to pay this fee at your next appointment or if it is not paid within 7 days it will be charged to your credit card on file.

____All clients are required to provide credit card information, there are two options to choose from. You may elect to have your information securely stored on the Ivy Pay application. This is a secure and confidential electronic payment system in which you enter your credit card information and your therapist is able to charge your card via the application through the use of your phone number. The other option is to fill out the space provided below with your credit card information and it will be securely kept on file in your electronic health record.

Card Number:_____ Expiration Date:_____

Card Type: VISA MC AMEX DIS Security Code:_____ Zip Code:_____

_____I will be utilizing the self-pay option offered by my therapist. The agreed upon payment will be _____ per session.
_____I will be utilizing my health insurance and authorize Positive Mind Counseling to release necessary information to process claims and collect payment.

_____

Client Name Printed

_____ _____

Client or Parent/Guardian Signature Date