# Saratoga Counseling Solutions

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## Confidential Background Information

Name: _____ Date: _____

Address: _____ SS#: _____

_____ Date of Birth: _____

_____ Number of Children: _____

Phone: (H) _____ Marital Status: _____

(W) _____ Occupation: _____

(Cell) _____ Email: _____

Referred By: _____

Briefly describe your reason for coming here:

_____

_____

_____

Please list any previous psychiatric, psychological/counseling treatments, including dates.

_____

_____

Are you currently under the care of a physician? Yes No

Are you currently taking any medications? Yes No

Please List Medications: _____

_____

**HOW MAY I CONTACT YOU**

Which telephone numbers may we use to confirm or change appointment times? (Please Circle)

**Home Work Cell Do Not Call**

By signing below, you agree that we may contact you in the manner indicated above:

Signature: _____

**FINANCIAL AGREEMENT**

Your financial obligation depends on whether you are using managed health care (such as HMO or PPO), or whether you are choosing not to use insurance, or you have an insurance plan that pays a percentage of the total charge (such as 80/20 split plans).

Self-pay rate of $ _____ per session. (This is for self-pay or 80/20 split plans).

Copay of $ _____ per session *. (For managed care such as HMO and PPO's)

*Please be advised that should your copay be greater than that stated above, you will be responsible for the additional funds due.

**Please initial EACH line acknowledging your agreement to the following terms of this agreement.**

_____ I understand and agree that I am directly responsible to the Saratoga Counseling Solutions for all bills submitted and services rendered.

_____ I understand and agree that I will be charged for appointments, which are cancelled with less than 24 hours notification and for appointments for which I do not show.

If you are using insurance, you must initial these statements as well.
_____ I understand and agree that although Saratoga Counseling Solutions will contact my insurance company in order to obtain my benefits, the benefits information may be different than what my insurance company actually pays (ie., I may be told that your copay is only $15, but after submitting the claim, I learn it was actually $25, you will be responsible for the additional $10 that you are required to pay by your insurance company).

_____ I understand that if my insurance company requires pre-authorization prior to being seen, I will make the necessary arrangements to obtain it. Otherwise, I will be responsible for the full contracted rate agreed on between my therapist and my insurance company.

_____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. By signing below, you acknowledge your understanding and acceptance of the terms of agreement.

Printed Name: _____ Signature _____

Date: _____

## CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and **Saratoga Counseling Solutions**. By signing this form you are agreeing to allow us to use your information and send it to others (i.e insurance companies to collect payments, billing company, etc). The notice of Privacy Practices (NPP) explains in more details your rights, and how we can share your information. Please read before signing this consent form.

If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices (NPP), We are unable to treat you.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing and we will do our best to accommodate you.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us that you no longer consent).

_____ _____

Signature of patient or responsible party Date

_____ _____

Printed name of patient or responsible party Relationship to patient

## INSURANCE INFORMATION

Name of Insurance: _____

Member Number: _____

Group Number: _____

Claims Address on card: _____

Insurance Phone Number: _____

# Privacy of Information Policies

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.** Effective 4-14-03

## Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

## Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

## Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and ad- ministrative proceedings, law enforcement purposes, serious threats to public safety, essential government func- tions, military, and when complying with worker's compensation laws.

**Abuse**

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**In the Event of a Client's Death**

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

**Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

**Other Provisions**

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner,

collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time- frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

**Your Rights**

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. There is a charge for this service, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

**Complaints**

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Melissa McCabe Mental Health Counseling. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: _____

**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.**

Client's name (please print):

Signature: Date: _____/_____/_____ Signed by: __client __guardian __personal representative

_____

# Untimely Cancellation/No-Show Policy

Please remember to cancel or reschedule 24 hours in advance as there is a significant demand for mental health appointments. Unfortunately, many people have to wait extended periods of time to see a therapist. When a session is cancelled without adequate notice, therapists are unable to fill this time slot.

You will be charged the **full fee (Insurance allowable)** for the appointment if there is not at least **24-hour's notice** of cancellation of an appointment ("***untimely cancellation***") or if there is a failure to show up for scheduled appointment ("**no show**"). Please note that payment for missed appointments is not reimbursed by your insurance provider.

Consecutive and/or frequent (subject to occurrence of appointments) **"*untimely cancellations***" or **"no shows",** may result in termination of your treatment.

This office values your time as much as our own. If your therapist is late/running late, you **will** receive your **full session time** (50 min). We make every effort to keep appointments running on time. There are emergencies that occur in the mental health field that could make your therapist run late, and we ask your patience in these circumstances.

I have carefully read, understand, and agree to comply with the above Untimely Cancellation/No-Show Policy,

_____ _____

Client Name (print) Signature Date

_____. _____

Parent Name (Print) — (If under 18) Signature Date

# 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<br>☐ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I, _____, authorize Melissa McCabe Mental Health Counseling 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