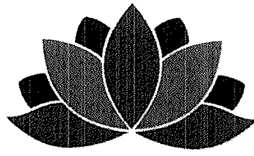


Date of Initial Visit: ___________

Patient ID #: ___________

PATIENT INFORMATION:

Full name: ______________________________ Date of Birth: __ / __ / __

Home Address: ____________________ City:__________ State: ____ Zip: ________

Phone: ______________ Employer or School (if student): ______________

Referred By: ____________________________ Physician: ______________

Person to Contact in Emergency: ______________________ Phone: ______________

Email address________________________________

INSURED/RESPONSIBLE PARTY INFORMATION

Full Name of Insured: ____________________ Relationship: ______ Date of Birth: __ / __ / __

Home Address: __________________________ Phone: ____________________

City: ______________ State: ___ Zip: ________ Employer: __________

Insured's Primary Insurance Co.: ____________________

I.D. No.: ________________________________ Group No.: __________

Name of Policy Holder____________________ Relationship to Patient______________

Address of Policy Holder________________________

Policy Holder's Birthdate ______________

Policy Holder's SSN ________ Policy Holder's Employer__________________

I have a secondary insurance policy (please specify).

Carrier Name: ________________________________

ID #:______________________________

Please initial if you will not be using insurance to pay for services rendered

Initials________

RELEASE AND ASSIGNMENT

I authorize the release of any information necessary to process my insurance claims and assign and request payment to my provider. I have received a copy of Namaste Holistic Counseling PC Notice of Privacy Practices.

Signature ________________________ Date ________

Namaste Holistic Counseling, P.C., 1056 Corporate Drive Unit K Export, PA 15632
* 412-639-9570 * www.namasteholisticcounseling.com

FINANCIAL AGREEMENT

I agree to fully investigate my insurance benefits and take responsibility for paying all amounts not paid by my insurance company. I agree to bring physical payment for copays and all services provided at the time of the office visit.

CO-INSURANCE/DEDUCTIBLE:

If my insurance policy only covers a portion of the amount of each session (i.e., I am responsible for co-insurance, or a percentage of the cost of the session), or if my policy is subject to a deductible that has not been met or any outstanding balances. I agree to bring some form of payment when services are rendered. Please confirm any outstanding balances prior to services. I agree to forfeit my appointment if I come without full payment (self pay rate, copay, co-insurance, deductible, or any other past-due balance), and agree to compensate the therapist for his/her reserved time, as outlined in paragraph below (with a $85.00 charge) 5 every three weeks for the length of time an unpaid balance remains unpaid, and understand that if my account is unpaid for 60-90 days, my account will go to collections, and that I am responsible for all reasonable costs associated with collection agency and/or legal efforts. I understand that if my account goes to collections, it cannot be removed, and that I cannot be an active client with unpaid balances.

INSURANCE COVERAGE

Namaste Holistic Counseling participates with Highmark,Optum and United Behavioral Health products with the exception of Medicare and Medicaid products within those plans. I can consult with my insurance company to better understand my policy benefits

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions and I authorize the release of information to my insurance company.
2. I have been given information on privacy practices, client rights and responsibilities.
3. I authorize direct payment to my service provider, Namaste Holistic Counseling P.C.
4. I understand that I am responsible for any deductible amount, co-pay, co-insurance amount or if paying myself, the full amount of my bill for services provided. I understand there will be a $25 service charge on returned checks.
5. I understand there is a 24-hour cancellation policy and that I must cancel my appointment 24 hours in advance to avoid incurring a "no show"/late cancel fee.

FOR LATE CANCELLATION PURPOSES ONLY (REQUIRED): A $85.00 charge will be applied to your account.

Card Type (circle one)
VISA MASTERCARD DISCOVER AMEX
Name on Card: ____________________
Number: ____________________
Expiration Date: _____/______ 3Digit Code ____________
Credit Card Billing Zip Code: ____________
Please note: Health Spending Account debit/credit cards are not accepted for late cancellation purposes

Signature:____________________

INFORMED CONSENT

1. I give my authorization and consent to receive outpatient diagnostic and treatment services having discussed the advantages/disadvantages of the recommended treatment.

2. I will address any concerns or grievances with my therapist.

3. I understand that while psychotherapy is confidential, there are limits to my rights to confidentiality, such as situations of danger to myself or another, as well as legal mandates from a judge.

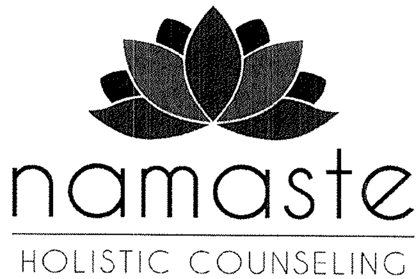
4. I understand that my therapist may seek professional direction and support for my treatment by consulting with one of his consultation teams.

5. I am choosing to enter into psychotherapy treatment and may discontinue at any time.

Signature ____ Date:______________________

I agree to communications via email/text and understand/accept the risk that they may not be secure.

Signature ____ Date______________________



Namaste Holistic Counseling is HIPAA compliant and will not leave a message regardless of the reason unless we have prior approval for each patient. If for any reason, my phone number, address, or insurance changes I will update my information with the front desk.

I hereby allow the practice staff to leave a message if necessary for any of the following reasons:

- ☐ Appointment changes
- ☐ Insurance questions
- ☐ Completion of labs
- ☐ Prescription Questions
- ☐ Disability/legal paperwork
- ☐ Other

☐ **Check if you want Text Message Reminders.**

Phone Number(s) allowed:

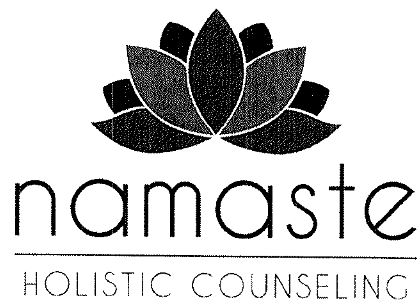
________________________ ________________________

________________________ ________________________

Patient has provided consent to receive automated text and voice message reminders at the phone number(s) listed in the patient's profile

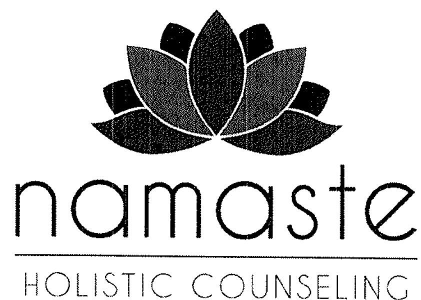
Name *(Printed)*: ____

Signature: ______________________________ Date: ________________

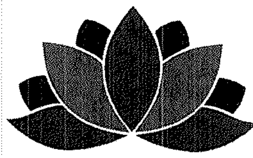


Telehealth Informed Consent Form I

____, consent to engaging in telehealth services with Namaste Holistic Counseling as a part of the counseling/therapy process and my treatment goals. I understand that telehealth counseling/psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and counseling/therapy. Telehealth will occur primarily through interactive messaging, audio, video, telephone and/or other audio/video communications via Psychology Today, Zoom and Vee Platform (a HIPAA compliant system application utilized by our practice and also downloadable to my smartphone and/or computer). I understand I have the following rights with respect to telehealth: 1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible. 2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent. 3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Namaste Holistic Counseling PC that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could



be interrupted by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete and thorough as in-person services. I understand that if my counselor/therapist believes I would be better served by other interventions I will be referred to other services and/or service providers as needed. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my counselor/therapist, my condition may not improve, or may have the potential to get worse. 4) I understand that telehealth services may or may not be covered by my insurance, regardless of my in-person services coverage and that it is my responsibility to investigate my telehealth services coverage with my insurance company prior to receiving telehealth services. I understand that I will be financially responsible for any out-of-pocket cost for telehealth services not covered/reimbursed by my insurance company. 5) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Psychology Today, Zoom and Vee, are HIPAA compliant are technology dependent and therefore not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Namaste Holistic Counseling PC or its staff liable for gathering or use of client information by these service providers. 6) I understand I have the right to access my personal information and copies of information contained within my client chart. I have read and understand the information provided above. I have discussed these points with my counselor/therapist, and all of



namaste

HOLISTIC COUNSELING

my questions regarding the above matters have been answered to my approval. 7) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for phone/audio/video/computer-based counseling/psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that crisis/emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or crisis/emergency, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies (for Westmoreland County 1-800-836-6010) or the National Suicide Prevention Lifeline at 1-800-273-8255.

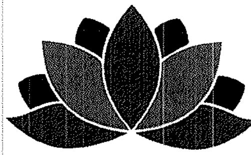
Preferred Phone Number for Telehealth: 412.639.9570

Preferred Email Address for Telehealth ____________________________

Print Client Name: ___________________________________

Client Signature: _________________________________ **Date**______________

Signature of Guardian if (patient under the age of 14)_____________________________



namaste

HOLISTIC COUNSELING

For your convenience, you may pay with credit card, please complete the information below and remit payment to the following address.

I,______________________________ authorize Namaste Holistic Counseling PC to charge my credit card for any outstanding balances such as copayments, co -insurance and deductibles. I understand this information will be saved to my file for automatic payments to my account.

Namaste Holistic Counseling PC
Billing Department
PO BOX 2124
Lower Burrell, PA 15068

Patient Name:____

Credit Card Number:____

Expiration Date:_______________________________

Code on Back:_________________________________

Zip Code:_____________________________________

Signature____________________ Date ______________________

If you have any questions, please feel free to contact the office at 412.639.9570

Thank you

Consent for Release of Information

I hereby authorize ______________________ to release information from the records of

___________________________ D.O.B. ________________.

By checking this box I authorize information to be exchanged freely by both parties identified in this release

The information to be released is:

Psychiatric Evaluation ___
Medical History ___
Social History ___
Discharge Summary ___
Course of Treatment ___
Lab Reports ___
Medications ___

Developmental History ___
Academic/School Records ___
Attendance Records/Appointments ___
Teachers/Counselors Comments ___
Complete Behavioral Checklist ___
Recommendations ___
Psych/Achievement Tests ___

Other (specify): ____

Records are requested for the purpose of: ____

Dates of Service Requested: ____

(Please note: HIV, Mental Health, and Drug and Alcohol information contained in this consent will be released unless indicated.)

Do not release:
Mental Health _______ HIV _______ Drug and Alcohol ______

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the person I authorized above to release the information. If applicable, specify other expiration date here.

Signature:_______________________________________ Date: ______________________

Please forward Information to:

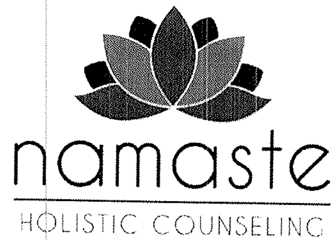
Name of person/facility: ________________________________
Address: ____
Phone/Fax Number: ___________________________________

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release is necessary and this permission is limited for the purposes and to the person listed above, and will be effective during the date listed below. I also understand that this consent is revocable except to the extent which records have been sent.

This consent shall be in effect from: ______________ **until** ____________________

Patient Signature: ____________________________________ Date: __________
Legal Guardian Signature: _______________________________ Date: __________
Authorized Representative Signature: _______________________ Date: __________

Oral Consent (NOT VALID FOR D&A!!) Dated: ________________
Authorized Representative Signature: ___________________________________
Authorized Witness Signature: ____



CLIENT SATISFACTION SURVEY

	Strongly Agree 5	Agree 4	Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable
I found the waiting room was comfortable and inviting						
The front office staff was friendly and helpful for my needs						
Staff worked with me in setting up appointments						
I found that my counselor's office created a pleasant environment for sessions						
I felt that my counselor listened to me and I could talk about anything I needed to during our sessions						
I was able to gain healthier coping skills to handle high risk situations and/or feelings						
I was given appropriate resources within the community (psychiatrist, case manager						

Please list three things that were most helpful in your treatment:

____

____

____

Additional Comments

____

____

____

OPTIONAL: What is your provider's name ______________________

Thank you for your time in completing our survey. It is very important to us to deliver a high level of quality care.

Namaste Holistic Counseling, P.C.,
1056 Corporate Lane Export PA 15632
Phone: 412-639-9570
Fax: 724-704-8164