namaste
HOLISTIC COUNSELING

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: _____

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 _____

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_____

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Consent to Treatment:

I, the undersigned, do voluntarily consent to psychological services provided at Namaste Holistic Counseling.

I am aware that the practice of psychology is not an exact science, and no assurances have been made to me about outcome, consequences, and/or results of services.

I am aware that I may terminate services with my clinician at Namaste Holistic Counseling at any time. Upon verbal or written notification of the end of treatment, my clinician will terminate all agreements and consents to release information, except in the case of an extreme emergency or imminent risk of harm, injury, or death to myself and/or others. If there is no formal notification of the end of treatment, I understand that all consents and agreements shall become invalid thirty days after the last scheduled appointment, even if I did not appear in person. No information will be released after thirty days of an unplanned discharge from treatment unless there is an extreme emergency or imminent risk of harm, injury, or death to myself and/or others.

I consent to my clinician at Namaste Holistic Counseling to release routine information to third-party insurers or payors (family members/friends) about my services, providing this is restricted to billing and payment information.

I am aware that the information that I give to my clinician will not be released under any circumstances, except when the following occurs:

1. When I provide written authorization and consent to release information, and the consent specifies the purpose and information to be released. The consent must be properly signed with an original signature.
2. If I am receiving emergency care and treatment, I am aware that information may be released to healthcare workers and others necessary to respond to an emergency.
3. If I use insanity as a defense in a criminal legal proceeding, I am aware that I relinquish my rights to control the release of information of my treatment information to the courts and their officials.
4. When my clinician is mandated to report child abuse and as stipulated by the Commonwealth of Pennsylvania, I am aware that information necessary to report child abuse will be released without my consent. I understand that my clinician at Namaste Holistic Counseling is a mandated report of child abuse when he/she comes to suspect a child is being abused, even if he/she has no contact with the child and the child is not his/her client.
5. Regarding children/adolescents: I am aware that my clinician will reveal general information about my sessions to my parents to summarize progress, risks, concerns, and treatment planning. I am aware that if I am harmful to myself or others, engage in high-risk behaviors (like excessive use of drugs, alcohol, or sex) that my clinician could consult with my parents without my permission.

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6. I am aware that if I am at imminent risk of hurting myself or someone else that my clinician will release information that is necessary to manage these situations and threats without my consent.
7. I understand that if I am attending group or family therapy I am consenting to releasing information to other members of the treatment who are attending those sessions with me. Information revealed in separate and individual sessions remains confidential, however if it is determined to be detrimental to the treatment, I may be advised to share this information and/or terminate group treatment.
8. If special arrangements have been made to bill my insurance company, I am aware that my clinician has my permission to release information necessary to respond to the company's requests. This may include dates of service, type of service, treatment plans, prognosis, diagnosis, assessment of progress, and in some cases session notes.

I am aware that by agreeing to receive psychological services that I am assuming responsibility for the costs and fees of services.

I understand that if I do not cancel my services within 24 hours I will be charged in full for the appointment.

Signatures:

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Clinician Signature Date

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

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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

Phone Number(s) allowed:

_____ _____

_____ _____

Name *(Printed)*: _____

Signature: _____ Date: _____