Faithful Counseling and Therapy Services, LLC

Patient Information

First Name _____ MI_____ Last Name _____

Street Address_____City_____State_____Zip_____

Cell Phone_____ Email Address_____

Communication Preferences: **Permission to leave VM message?** Yes □ No □ **Permission to text?** Yes □ No □

Permission to email Yes□ No □

Date of Birth_____Age_____

GUARANTOR INFORMATION

LEGAL GUARDIAN, OR WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

First Name _____ MI_____ Last Name _____

Street Address_____City_____State_____Zip_____

Cell Phone_____ Email Address_____

Communication Preferences: **Permission to leave VM message?** Yes □ No □ **Permission to text?** Yes □ No □

Permission to email Yes□ No □

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its officers, agents, employees and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient OR Guarantor Signature (if patient is a minor or incapacitated adult)

Name_____ Date_____

Faithful
Counseling and Therapy
Services, LLC

INFORMED CONSENT

Welcome to Faithful Counseling and Therapy Services, LLC. Our goal is to provide therapeutic services to better and/or improve everyday life functioning. Please review the following with your individual provider and ask any questions you may have. We know that starting counseling services is a big decision and we are privileged to be working with you during this time.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company (if applicable) to process your claims, b) information you and/or you child/children report about physical or sexual abuse; then, by Indiana state law, Providers are obligated to report this to the Department of Children Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. **If an emergency situation for which you feel immediate attention is necessary, you are to contact the emergency services in the community (911) for those services.** Emergency services will be followed up with standard counseling and support to your family.

In case of emergency, whom would you like me to call?

Name:_____ Phone #: _____Relationship: _____

CANCELLATION POLICY:
Engaging in therapy services is an endeavor that takes the commitment of both the client and the therapist to be most effective. It is important to keep your weekly appointment. If you are unable to make an appointment, please give 24 hours notice to cancel. Every effort will be made to reschedule to keep the momentum of therapy. If you do not give 24 hours notice, your account will be charged $100. As a courtesy, you will be allowed ONE late notice cancellation per year at no charge.

COPAYS PAYABLE AT TIME OF SERVICE:
As a courtesy, your insurance will be billed for the service provided, however copays are due at the time of service. Any outstanding balance will be billed monthly. Payment is expected upon receipt of invoice. If payments aren't received in a timely manner, a credit card will be required and put on file to be charged directly in order to continue with therapy services. For your convenience, there are several ways to pay including PayPal, ApplePay, Zelle, and Venmo.

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost of withdrawing. I understand that I will be given a copy of this consent form if requested.

Signature _____ **Date:**_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: May 2022

Faithful Counseling and Therapy Services, LLC has been and will always be totally committed to maintaining clients' confidentiality. Information will only be released in accordance with federal and state laws and ethics of the counseling profession. This notice describes policies related to the use and disclosure of your healthcare information for both in person and telehealth services.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources. Telehealth services are available, however do know that in person services are available at the practice office address of 57 Michigan Ave, Suite 100, Valparaiso, IN.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance. Also be informed that claims may be processed electronically.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance, and licensing activities.

Other uses or disclosures of your information which do not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Indiana State Law, we are obligated to report this to the Department of Children Services. If you provide information that informs us that you are in danger of harming yourself or others: then by Indiana State Law, we are obligated to report this to the local law enforcement. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Signature(s) _____ **Date:**_____

Faithful Counseling and Therapy Services, LLC

Know exactly what your charges will be for services by calling your insurance directly

(This sheet will have all the information you will need when calling your commercial insurance carrier to get information on copays and deductibles***)

Verification of Benefits

Insured Name: _____ Date of Birth: _____

Primary Insurance Company**:** _____ Insurance Company Phone: _____

Policy Holders Name: _____ Policy Holder's Date of Birth: _____

Relationship to client: _____ Policy Holder's Employer: _____

Policy or ID Number: _____ Group Number: _____

Is Debbie Sardina NPI # 1770697716 an In Network Provider YES or NO

Deductible Remaining: _____ CoPay per session: _____/ Co insurance (% paid)_____

Out of Pocket Remaining: _____ Out of network benefits? Yes or No

Do you have any other questions to clarify how much is your financial responsibility for services? Please do not hang up until you fully understand your benefits :)

Name of Insurance representative: _____Date and Time of call: _____

******Remember that copays are due at the time of services and any balance remaining is due upon receipt per Faithful Counseling and Therapy Services, LLC policy.***