Date __________

Summit Counseling Center

Welcome! The following information is provided to our clients to assist in understanding the policies and procedures at our office. We strive to provide care which is both affordable and of the highest quality. Please do not hesitate to ask questions of us, or our administrative staff, at any time about these matters.

Identifying Information – Please Complete Fully

If a child is the patient, please complete information for the child. If you are coming for marriage/relationship counseling, please complete one packet per individual:

Full name of patient (self or child) ________________________________

Status: Married / Single / Other Sex: Male / Female Date of Birth ______________ Age ________

Home Address ____
Street City State Zip

Mobile Phone: ______________________ Reminder Messages OK? Y/N Text OK? Y/N

Home Phone:______________________ Reminder Messages OK? Y/N

Email: ______________________ May we contact you at this address? Y/N

Emergency Contact: Full Name ______________________ Relationship to Client: ______________

Phone Number: ______________________

Employer: ______________________

Work Phone: ______________ May we contact you at this number? Y/N

Who referred you/how did you hear about us? ______________________

Have you attended counseling before? Y / N If yes, whom did you see and when/why did you see them? (Please include any past diagnoses/conditions)

____

Are you currently taking any medication? If so, please list (type/dose/perscriber):______________________
____

Main Concerns/Reasons for Coming: ______________________

For Patients under 18 ONLY…

Mother – Name: ______________________ Phone Number: ______________________

D.O. B: ______________ Address: ______________________

Father – Name: ______________________ Phone Number: ______________________

D.O.B: ______________ Address: ______________________

Parents Marital Status: Married / Separated / Divorced (If so, who has custody?) ______________

(Please provide copies of any legal documents supporting custody status)

Child lives with:______________________

School attended/ grade: ______________________

SUMMIT COUNSELING CENTER

Please circle any of the following concerns that apply:

Stress	Death/Grief	Financial Problems	Nightmares	Irritability
Anxiety/ Fear	Suicidal Thoughts	Sexual Problems	Tiredness	Headaches
Anger	Homicidal Thoughts	Physical Abuse	Sleep Problems	Loss of Memory
Guilt	Procrastination	Marital Problems	Attention Problems (ADD/ADHD)	Unable to concentrate
Loneliness	Academics	Family Conflicts	Eating Problems	Tightness of chest
Depression/ Unhappiness	Career	Dating Conflicts	Obsessive/ Compulsive Behavior	Shakiness
Shyness	Lack of goals	Poor Social Relationships	Physical Health	Rapid/Skipping Heartbeat
Self - Esteem	Self-Injury	Pornography	Body Image	Alcohol/ Drug Abuse

Appointment Policy / Missed Appointment Fee

Since patients are seen by appointment only, appointment times are considered a reservation. For this reason, all clients wishing to make an appointment reservation with a counselor must provide a credit card number to be kept securely on file (or prepay $50 towards their account). This card (or deposit) is used to cover the cost of a **$50 missed appointment fee**, which applies if a client fails to show up for an appointment, or cancels an appointment less than 24hrs in advance. This fee is to reimburse the counselor for their missed hour. **No fee applies if notice is provided 24 hours in advance.** Please understand that insurance companies cannot be charged for missed appointments and you are fully responsible for these fees. If you miss multiple appointments, please call our office as soon as possible or any future appointments may be cancelled, at your counselor's discretion. Feel free to discuss any concerns you may have regarding this policy with your counselor.

(If couple's/relationship counseling, please note that the card listed below will be charged for **ALL** missed appointment fees, unless other arrangements have been made with the office staff prior to the missed session.)

Credit Card # ______________________________ Exp Date: __________

Cardholder Name: ______________________________ CVC Code: __________

I have read and agree to the Summit's appointment policy. I understand that I will be charged a $50 fee if I do not give 24 hours notice to cancel an appointment or if I miss an appointment.

____

Signature of Patient (of parent/legal guardian of patient less than 18 years of age) Date

SUMMIT COUNSELING CENTER

Coordination of Care

In the process of providing quality mental health care for you, and to fulfill obligations to managed care contracts, Summit Counseling Center requests your permission to notify your primary care physician of your decision to seek services. Please complete the following and our office will coordinate care with your medical doctor.

Patient Name **Date of Birth**

Patient's Primary Care Physician **Telephone #**

I hereby **GIVE** my permission for Summit Counseling Center to notify my (or my child's) primary care physician of my decision to seek mental health services for myself or my legal dependent named above, and to share information in order to coordinate care. The release of this information form is reciprocal.

Signature of Patient (or Parent/Legal Guardian) **Date**

Signature of Witness **Date**

Summit Counseling Center Provider

OR

I **DECLINE** the option of coordinating care with my primary care physician.

Signature of Patient (or Parent/Legal Guardian) **Date**

SUMMIT COUNSELING CENTER

Billing / Financial Responsibility

Financially Responsible Party: Self / Other (If other, please provide information below)

Name: ____ Phone Number: ________________________

Relationship to Client: ________________________________ Email: ________________________________

Mailing Address: ____

It is the policy of the *Summit Counseling Center* that the appointment fee is to be paid prior to the beginning of each session. Once you arrive for your appointment, the receptionist will take your fee and let your clinician know that you are present. If you do not have the ability to pay for an upcoming session, then you will need to cancel your appointment in advance and reschedule for another session. The session fee may be paid by cash, check, or credit card. There will be a $25.00 processing fee for returned checks. If you will be having Summit file for reimbursement through your insurance company, you will be responsible to make payment of either your deductible amount or co-pay the day of your session. Special fee structures for certain specified tasks such as vocational testing and consulting will be discussed with you and agreed upon in advance. Some patients are eligible for a discounted fee if no insurance coverage is available.

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment is expected at the time services are rendered.

____

Signature of Patient/Financially Responsible Party **Date**

Court Appearance and Legal Testimony

It is the policy of the Summit not to become involved in cases that will, or are likely to necessitate court-ordered testimony or the surrendering of patient records. If your situation will or is likely to require this, let your counselor know <u>before your initial session</u>. Time spent for legal services (depositions, court appearances, records requests, etc.) will incure separate, non-insurance billable fees. Your signature indicates your understanding.

____

Signature of Patient (or parent/legal guardian of patient less than 18 years of age.) Date

SUMMIT COUNSELING CENTER

Patient Notification of Privacy Rights

You have the right to review your privacy rights titled Patient Notification of Privacy Rights in the notebook which we will give on request. This document is now required with the passage of the federal "medical records privacy law" known as HIPAA (Health Insurance Portability and Accountability Act). We are required by law to provide you access to a copy of this document and to secure your signature indicating you have read a copy of it and have had an opportunity to ask any pertinent questions. Laws such as these are important, but also complex, and in our Patient Notification of Privacy Rights document we have tried to inform you about your rights in plain, simple language. Please read the notification and do not hesitate to ask your counselor about any questions you might have about these matters.

We understand the importance of privacy and are committed to maintaining the confidentiality of your health information. We make a record of your health information and may receive such records from others. We use these records to provide or enable other health care providers to provide quality health care, to obtain payment for services provided to you are allowed by your health plan and to enable us to meet our professional and legal obligations to operate this mental health practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. Summit Counseling is in compliance with HIPAA Confidentiality Rules and Regulations. For more information, please see the receptionist for a HIPAA Information Packet.

The Health Insurance Portability and Accountability Act (HIPAA) Has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data (the transaction rules), the keeping and use of patient records (privacy rules), and storage and access to health care records (the security rules). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple, yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Summit Counseling Center is required to secure your signature by indicating you have received/read this Patient Notification of Privacy Rights. Thank you for your thoughtful consideration of these matters.

Jon E. Harris, M.A., LPC-MHSP

HIPAA Compliance Officer

I, ______________________________, understand the Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document before signing this "acknowledgement form."

____

Signature of Patient (or parent/legal guardian of patient less than 18 years of age) Date

____

Witness Date

SUMMIT COUNSELING CENTER

Insurance Information

Please provide the information regarding insurance(s) and/or health plan(s) to be utilized:

Primary Insurance Company: ____

Primary Policy Holder: ______________________________________ D.O.B.___________________

Insured's ID #: ________________________________ Insured's Group #: __________________

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) to which I subscribe and in which the clinician is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, that Summit will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Prior to your first appointment we will obtain a benefit estimate from your insurance company. Please understand that the insurance company does not guarantee benefit estimates, the final determination of benefits is made at the time the claim is received by your insurance company. The amount we charge you at each visit is based on this benefit estimate, however we cannot guarantee accuracy of this estimate. We ask that you maintain communication with us regarding any changes in your insurance over the course of your treatment (copayment changes, deductible restarting, benefit loss, changing to another plan, etc.) Payment for any charges denied or not covered by my insurance company become my full responsibility and I agree to pay these charges. In addition, if I have requested that Summit file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that Summit provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the clinician to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

I hereby authorize my insurance benefits to be paid directly to the Summit Counseling Center for the services rendered. I understand and accept full financial responsibility for all non-covered charges or services.

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Signature of Patient (or parent/legal guardian of patient less than 18 years of age) Date

____

Signature of Financially Responsible Party (if other than patient)) Date

NOTE: For clients seeking relationship-focused/marriage (or pre-marital) counseling, please be aware that this is ***not*** *considered a medically-necessary or insurance-billable service, and therefore we do not file claims for these types of sessions. Health insurance companies require the counselor to diagnosis an individual patient with a medically-recognized area of concern in order to consider payment services. Mediation, conflict resolution, negotiation, parental consulting, etc. are therefore generally not payable under health insurance contracts. We do have a number of counselors who provide these services at a range of cash -pay rates.*

Patient Agreement with Policies and Procedures / Informed Consent

SUMMIT COUNSELING CENTER

Your Informed Consent to Care:

INTAKE INTERVIEW: The intake interview is an opportunity for the clinician and patient to begin the work of identifying and evaluating the situation the patient is presenting. A main goal of this initial interview is to match the identified needs of the patient with the most helpful resources available. Occasionally, this will mean a referral to another clinician at Summit or an outside agency. If this is the case, Summit will make every effort to reconnect the patient with the therapeutic resources best suited to meet the needs he or she initially presents.

LIMITATIONS OF SERVICES: I understand that Summit services are limited to psychological and spiritual evaluation, assessment, consultation, and intervention. I understand that evaluation and assessment services may also include the use of psychological tests. I understand that intervention services may include prayer, counseling, and psychotherapy oriented toward helping one face life's challenges from a biblical perspective, if consistent with the client's beliefs/desires. I understand that Summit is not promising a cure or offering any guarantee of results or improvement of any condition. I understand that while Tennessee law may permit minors sixteen years and older to consent to mental health care without parental consent, Summit does not treat minors without parental permission or authorization.

ASSUMPTION OF RISKS: I understand that the potential benefits of undergoing psychological and/or counseling services may include obtaining a professional opinion and an increased understanding of myself. I understand that potential risks may include limited precision of psychological assessment procedures, possible disagreement with the services offered to me, and possible emotional distress concerning my situation.

IN HOUSE RELEASE OF INFORMATION: To provide you with the best possible service at times it may be necessary for your counselor to consult with the other Summit counselors about the care you are receiving.

CONFIDENTIALITY: Information discussed in counseling sessions is held in CONFIDENCE. There are exceptions to this rule, however. Information may be disclosed under the conditions of an order of the court, or if there is a reason to suspect that a patient poses a threat to self or others. In instances of child/elder/handicapped person abuse or threat of harm, information may also be shared. In the case of a minor, certain information may be shared with a parent when it is deemed to be necessary for the best interest of the minor. This information will be discussed with the minor prior to disclosure.

Your Summit clinician has provided this information to you in the hope of fully informing you about the policies of our office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problem in question, you are invited to discuss your treatment plan with your Summit clinician. After discussing your concerns, an individualized treatment plan will be constructed and shared with you so that you and your clinician will have a plan for treating the problems that have been identified together.

By signing below, you acknowledge having read, understood, and of your agreeing to the policies and procedures of the Summit Counseling Center. Your signature also acknowledges your informed consent for care.

____

Signature of Patient (or parent/legal guardian of patient less than 18 years of age) Date

____

Co-Signature Patient 16-17 years of age Date

____

Witness Date