THE TRANSFORMATION CENTER

The Transformation Center Policies and Procedures

Welcome to The Transformation Center!
The following information is provided to our patients 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.

You have been offered a notebook to review your privacy rights titled "Patient Notification of Privacy Rights." 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.

Appointment Policy:
The Transformation Center is open Monday through Friday. The secretaries are here from 9am – 5pm. The telephone number is 423.499.9335. Since patients are seen by appointment only (unless an emergency situation dictates otherwise), the appointment time given is reserved for you. **You are required to give at least twenty-four (24) hours' notice if you must cancel your reserved time.** _____ (*Initial here*) Sometimes illnesses and emergencies happen which prevent you from keeping your reserved time. In those instances please call the office to let us know what happened as soon as possible, and there will not be a charge for these infrequent occurrences. In the absence of such circumstances, **you will automatically be charged the full session fee for appointments not cancelled twenty-four hours in advance of your reserved time**. Please understand that insurance companies cannot be billed for missed appointments, and you are fully responsible for any fee accrued due to a missed appointment. Patients arriving late to appointments are responsible for the regular session fee even though the full 50 minutes will not be available. **If a patient is more than 15 minutes late for an appointment, the insurance company cannot be billed, and the patient may be responsible for the full session fee**. In case of inclement weather (e.g., snow and ice) please call the office to determine if it will be open. A message will be updated on the voice mail system daily in such cases. Our office utilizes News Channel 9 for notices of office closings due to snow or ice.

No Show/ Missed Appointments:
If you miss an appointment, it is to your benefit to call us as soon as possible in order to let the office staff know if you have suffered an emergency situation. Otherwise, we will have to hold you accountable to the 24 hour cancellation policy and automatically charge for the full session cost. Insurance cannot be billed.

Missing Multiple Appointments:
Please call us if you miss multiple appointments to avoid your future appointments being cancelled. **If you miss 2 appointments in a row, due to our ongoing waiting list, we will have to cancel all future appointments until you call in to reschedule**. Additionally, you may be required to prepay for future appointments. If you miss 3 appointments in a row without calling the office to let us know why you missed the appointment, then your counselor may need to refer you to another counseling office. Please discuss any concerns you may have regarding this policy with your counselor.

Fees and Payments:
It is the policy of The Transformation 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, direct you to the waiting area, and let your clinician know that you are present. **If you are unable to pay for an upcoming session, then you will need to cancel your appointment 24 hours in advance and reschedule for another session**. The session fee may be paid using cash, check, VISA, MasterCard, Discover, or American Express. There will be a $5.00 processing fee for returned checks. 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.

Please be advised that you are required to provide and maintain on file a valid credit card number and authorization. This information will be maintained in strict confidentiality. Please also note that our payment processing system is in compliance with PCI requirements. **If you have a late cancellation or no show (as outlined above in the section titled "Appointment Policy") we reserve the right to automatically charge your credit card on file for the full session cost**.

THE TRANSFORMATION CENTER

I have read and agree to The Transformation Center's Appointment Policy and Fees and Payments Policy. I understand that I may automatically be charged the full session fee if I do not give 24 hours' notice to cancel an appointment.

_____

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

Court Appearance and Legal Testimony:
It is the policy of The Transformation Center not to become involved in patient cases that will, or are likely to necessitate court-ordered testimony or the surrendering of patient records. However, if your situation will or is likely to require this, please let your therapist know before your initial session begins. **Court requirements for patient records to be compiled by your counselor have a minimum charge of $45- $100 per document** (depending upon the complexity of the reports required). **In the event you or your attorney initiate a subpoena for your counselor to appear in court you agree to pay our standard fee of $150 per hour portal to portal**.
Your signature below indicates your agreement to the above terms.

_____

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

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 The Transformation Center or an outside agency. If this is the case, The Transformation Center will make every effort to connect the patient with the therapeutic resources best suited to meet the needs he or she initially presents.
LIMITATIONS OF SERVICES: I understand that The Transformation Center 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. I understand that The Transformation Center 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, The Transformation Center 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: In order to provide you with the best possible service, at times it may be necessary for your counselor to consult with the other Transformation Center counselors about the care you are receiving.

Fee Payment Information

Financially responsible party: ☐ Self-Pay ☐ Other **(IF it is NOT the patient)**
Please provide the following information about the Financially Responsible Party:

Name:_____ Age_____ SS#_____

Relationship to patient:_____ Home phone:_____ Work phone:_____

Employer:_____ Occupation:_____

Billing Address:_____

Payment Agreement

THE TRANSFORMATION CENTER

I accept responsibility for payment of fees for services rendered to the above named patient. I understand that full payment is expected at the time services are rendered. I understand and agree that I may automatically be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance.

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

Patient Agreement with Policies and Procedures

Your Transformation Center 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, like other things in life, 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 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.

Please feel free to discuss any of these matters with your clinician in more detail. By signing below, you acknowledge that you read, understand, and agree to the policies and procedures of The Transformation Center. Your signature acknowledges your informed consent for care.

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

Witness Date

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protection 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 rues), 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 other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal 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 in this document, please do not hesitate to ask for further clarification.

By law, The Transformation Center is required to secure your signature indicating you have reviewed this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Mark Carpenter, 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

☐ Copy of Patient Notification of Privacy Rights made available to patient/parent/personal representative.

THE TRANSFORMATION CENTER

Confidential Information – SECTION 1

Please Complete

IDENTIFYING INFORMATION
If your child is the patient, complete information on your child:

Full Name of Patient: _____ Date of First Appointment: _____

Sex: __Male __Female Date of Birth: _____ Age: _____ Education Level: _____

Home Address:_____

Phone Number(s): _____

Referred by: _____ Phone:_____

May we contact this person/agency to notify them of your follow through for an appointment?
☐ Yes ☐ No

Did you find us online?
If yes where? _____ Which search engine did you use? _____

Physician / Psychiatrist / Etc. (Doctor(s) seen routinely):

Name _____ Ph. ( ) _____ Years _____

Address_____ City _____ State _____ Zip_____

Name _____ Ph. ( ) _____ Years _____

Address_____ City _____ State _____ Zip_____

Any medical problems? Please explain:
_____

Patient's Current Medications:

Medication	Dosage	Taken as prescribed: Yes	No	Doctor	Reason	How Long?
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

Previous Mental Health Services:

Type of Services	Provider	Dates of Service

Current or expected legal involvement? ☐ Yes ☐ No
If yes, please explain: _____

Current Order of Protection? ☐ Yes ☐ No

If yes, please explain: _____

Person to notify in case of emergency:_____Relationship:_____
Address: _____Phone#_____

Religious affiliation:_____

Adults, complete the following questions on yourself. (Child clients – parents complete on your child):

Briefly describe the problems and reasons that brought you here:

_____
_____

Please list the symptoms you are currently suffering from (worry, depression, fear, sleep loss, irritability, etc.):

_____
_____

Briefly list goals of your treatment here; that is, what you would like to achieve and/or see happen by coming here for care:

_____
_____

Confidential Information – SECTION 2

ADULT Patients (18 & up) Please Complete

Cell Phone_____ Work Phone_____

Occupation_____ Employer_____

Work Address_____

Marital Status _____ Date of present marriage_____ Date(s) of previous marriage(s)_____

Spouse's name _____ Age_____ Spouse's Education _____

Spouse's occupation_____ Employer_____

Other Family Members
Place a check beside the name(s) of those with whom you now live. Circle (M)ale or (F)emale.

Spouse _____ Age _____ (M) (F)
Child(ren) _____ Age _____ (M) (F)
Mother _____ Age _____ (M) (F)
Father _____ Age _____ (M) (F)
_____ Age _____ (M) (F)
_____ Age _____ (M) (F)
_____ Age _____ (M) (F)

Past Addictions? If yes, please explain:

_____

Do any of your family members have a past history of mental health issues? If yes, please explain:

_____
_____

THE TRANSFORMATION CENTER

Confidential Information – SECTION 3

PARENTS Complete on Child Patients

Required Family Information
We need all of the following family information, please see the receptionist if you are not able to provide all of the information below.

CURRENT FAMILY SITUATION:
Mother's name _____ Date of Birth_____ Phone #_____

Relationship to child: ____ Natural parent ____ Step-parent ____ Adoptive parent ____ Relative _____

Age_____ Occupation _____ Employer _____

Father's Name_____ Date of Birth_____ Phone#_____

Relationship to child: ____ Natural parent ____ Step-parent ____ Adoptive parent ____ Relative _____

Age_____ Occupation _____ Employer _____

Do both parents have legal custody and rights to all medical and mental health information? Yes__ No__
If not, please explain:
_____

Marital History of Parents:

Natural Parents
__ Married/When _____
__ Separated/When _____
__ Divorced/When _____
__ Deceased/When _____

Step Parents
__ Married/When _____
__ Separated/When _____
__ Divorced/When _____
__ Deceased/When _____

(We will need a release on file for step parents to bring your child to the office and pay for visits, see receptionist)

If Child is Adopted
Adoption Source _____ Age of child at adoption _____ Date of adoption _____

Reason and circumstances
_____

What has the child been told about his/her adoption?
_____

Living Arrangements
Other Family Members: Place a check beside the name(s) of those with whom the child currently lives with. Circle (M)ale or (F)emale:

Siblings	*Parents*	*Grandparents*
_____ Age___ M/F	_____ Age___ M/F	_____ Age___M/F
_____ Age___ M/F	_____ Age___ M/F	_____ Age___M/F
_____ Age___ M/F	_____ Age___ M/F	_____ Age___M/F
_____ Age___ M/F	_____ Age___ M/F	_____ Age___M/F
_____ Age___ M/F	_____ Age___ M/F	_____ Age___M/F

THE TRANSFORMATION CENTER

Confidential Information – SECTION 4

Complete ONLY if You are Filing Insurance

Insurance Usage and Issues of Confidentiality and Privileged Communications
Many patients elect to file third party insurance coverage for services rendered. The Transformation Center will file insurance for you, provided you authorize us to do so and provide us with the necessary information for filing such claims. As you know, the world of healthcare has experienced a tremendous change in the manner in which insurance companies reimburse for third party payment. Many plans require an initial pre-certification of care before you can use your insurance benefits. **It is your responsibility to make sure such pre-certification requirements are met by you if you elect to use your insurance benefits.**

In filing your insurance claim for you, it is understood that you are granting The Transformation Center permission to reveal confidential information, such as the dates you are seen, the length of the appointment, and your diagnosis. This type of information is required by your carrier if you want insurance to pay your claim. Additionally, nearly all companies now require further utilization review and participation with outcome and quality measures. Unless your care is very, very brief, it is highly likely your treating clinician will be required to submit a more extensive report documenting the clinical and medical necessity for your care, as well as reveal some of the details of your care to date if further sessions are going to be authorized by your carrier. Many carriers will require auditing/review of your records for every visit here. Nearly all companies require participation in outcome and quality care studies such as patient satisfaction surveys. If your carrier requires such activities in order for you to use your insurance, The Transformation Center will comply with those requirements if that is your desire. **Your Transformation Center clinician's responsibility is to inform you about the compromising of your confidentiality and privacy when complying with such requirements.** The compromising of confidentiality is standard in today's marketplace whenever one elects to use third party insurance coverage for services rendered.

Fortunately, the newly enacted HIPAA regulations do provide you an increased degree of privacy and confidentiality regarding your protected health information. Payers of care can no longer make full release of your entire mental health record a condition for payment of your claims. Instead, The Transformation Center will be able to limit the release of your mental health record to only your designated mental health record set and not psychotherapy notes of sessions.

As explained in the Patient Notification of Privacy Rights document, the **designated mental health record is limited to the following information: billing information, paperwork you complete today, a summary of your initial visit today, your mental status examination, your comprehensive treatment plan, progress notes, any reports or clinical summaries, any correspondence with outside parties you authorized information to be released to, and any utilization review reports which have occurred regarding your care.** Mental Health Providers have a strong privileged communication law in Tennessee, which carries virtually the same legal status as that of attorney-client. *What you talk about in your established relationship with your clinician is protected by privileged communication laws and confidentiality principles, with the exception of certain specific actions (i.e., clear and imminent danger to self and/or others, suspected child abuse, worker's compensation related cases, Medicare Cases, if your psychiatric or psychological health becomes an issue in a lawsuit, whatever information is shared in utilization review reports for authorization of care, compliance with chart audits by your insurance carrier).* With these exceptions, unless you specifically sign a release of information authorizing your clinician to talk to someone, all communications here are kept private, confidential, and privileged (i.e., if someone calls here asking for you, Transformation Center staff will not acknowledge even knowing you unless you tell us otherwise). We strive to maintain the sacredness and privacy of your confidential communications with us.

Fee Payment Information – Section 4 Continued

Financially responsible party: ☐ Self-Pay ☐ Other **(IF it is NOT the patient)**
Please provide the following information about the Financially Responsible Party:

Name:_____ Age_____ SS#_____

THE TRANSFORMATION CENTER

Relationship to patient:_____ Home phone:_____ Work phone:_____

Employer:_____ Occupation:_____

Billing Address:_____

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

Primary Insurance Co.: _____ Insured's Name: _____ SS#:_____

Insured's DOB: _____ Insured's ID #:_____ Insured's Group #:_____

Insurance Company Address:_____

Insurance Company Phone #:_____

Secondary Insurance Co.: _____Insured's Name: _____ SS#_____

Insured's ID #:_____ Insured's Group #:_____

Insurance Company Address:_____

Insurance Company Phone #:_____

Payment Agreement & Authorization to Send Insurance Reimbursement Information

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, The Transformation Center 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. I also understand that any court order I have is an agreement between myself and the courts NOT the provider, and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. In addition, if I have requested that The Transformation Center file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that The Transformation Center 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 healthcare 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 Transformation Center for the services rendered. I understand and accept full financial responsibility for all non-covered charges or services.

_____ _____

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

THE TRANSFORMATION CENTER

PRE-AUTHORIZED CREDIT CARD USE (REQUIRED) / CLIENT RIGHTS

Client's name: _____Cardholder's Name:_____

Cardholder's Address: _____

Credit Card: □ Visa □ Master Card □ Discover □ American Express

By signing below you affirm that you have read, understand, and agree to this policy and authorize the use of this credit card (signature on file) for:

1. Co-payments or full payments for services rendered..
2. Charges due to late cancellations or missed appointments.
3. Denied insurance claims due to lapse in coverage, unmet deductible, policy changes, or changes in coverage.
4. Returned checks due to insufficient funds plus a $35.00 processing fee.

Signature_____ Date_____

CLIENT RIGHTS

1. To receive competent professional services.
2. To obtain information about the services provided to you.
3. Right to request how we contact you. It is our normal practice to communicate with you at your home address and daytime phone number you provided. We may leave messages on your voicemail. You have the right to request that our office communicate with you in a particular way.
4. Right to have input in the design and implementation of an individualized treatment plan.
5. Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing. However, we are not required to agree to such a request.
6. Right to terminate therapeutic services. I invite you to discuss any concerns you may have regarding the services provided to you so that an effort can be made to meet your specific needs.
7. Right to request a referral to adjunct services in the community for your benefit.

CLIENT RESPONSIBILITIES:

1. Clients are expected to pay the fee for each session of 45-50 minutes in length at the time that services are rendered. Telephone conversations will be limited to non-clinical issues. Clinical issues need to be discussed during sessions.
2. To keep your appointments or give 24 hours cancellation notice. You will be charged for late cancellations or no-shows.
3. To provide and maintain accurate information on all forms and requests for information.
4. To follow recommendations made by your therapist for yourself and/or your minor child.
5. To refrain from violent or threatening behavior or language.
6. To accept and follow through with referral services recommended for you and/or your minor child.

CONDITIONS UNDER WHICH THIS PROVIDER MAY DENY FURTHER SERVICES TO YOU:

1. If you refuse to cooperate with your provider or follow recommendations
2. If your needs are beyond the scope of what this psychotherapist may provide to you.
3. If you refuse to pay for the services provided at the time that services are rendered.
4. If you have repeat cancellations or no-shows, or if you refuse to pay these fees.

I/We have read and understand the content of this document.

_____ _____ _____

Client signature Client signature Date