Karen L. Collier, LCSW
10641 Hillary Court, Suite 1
Baton Rouge, LA 70810
(225) 387-3325

INFORMED CONSENT CHECKLIST FOR TELEHEALTH SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.

Patient Signature: _____

Date: _____

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Receipt of Notice of Privacy Practices

This is to certify that the HIPAA Notice of Privacy Practices has been made available to me regarding me as a patient or regarding my child, for whom I am a legal guardian.

_____
Signature of Patient or Authorized Party

_____
Date

_____
Witness

CONSENT FOR TREATMENT

I, _____, hereby consent to diagnosis and treatment of myself by **Karen L. Collier, LCSW.** In entering into this agreement, I understand that all mental health care, diagnosis and treatment is provided by the licensed professional person named above and not by Psychological Evaluation & Treatment Services.

I accept responsibility for payment of all usual and customary professional fees charged, **or** insurance deductibles and copayments set by my insurance carrier, managed care company, or other third party administrator, **and** that I am responsible for any expenses incurred that are not covered by such other entities (i.e. un-authorized procedure, telephone comunications to third parties or yourself, reports or other written communications, etc.). I understand that payment is due at the time services are rendered, unless other arrangements have been made in advance.

I understand further that all communications shall be held in professional confidence except for those circumstances provided by law or when I have given permission in writing for release of information on my behalf to a third party. Examples (**not a complete list**) of legal exceptions to the patient's privilege of confidentiality include the following:

* When you have filed a lawsuit placing your mental status at issue;

* When you have signed an agreement with some other person or company, such as your insurer, authorizing release of information;

* When your condition poses a danger to yourself or someone else;

* When evidence of abuse is revealed.

Cancellation of sessions, and re-scheduling of sessions, must be done at least *24 hours* in advance. *Answering service available 7 days a week, 24 hours a day. I*f you do not cancel/reschedule at least *24 hours* in advance, you will be charged $80. If you are going through an insurance company, you should know that they will **not** pay this cancellation fee; it will be an out-of-pocket expense for you.

_____ _____

Date Signature

_____

Witness

Karen L. Collier, LCSW

Client Information

****Please fill out entire form to the best of your ability****

Patient Name _____ **Today's Date** _____

Birthdate _____ **Age** _____ **Height** _____ **Weight** _____

Mailing Address _____

City _____ **State** _____ **Zip code** _____

Home Phone (____)_____ **Cell** (____)_____ **SSN#** _____-_____-_____

Email Address _____

Employer/Occupation _____ **Work Phone** (____)_____

Highest Grade Completed or Degree _____ **School** _____

Marital Status Single _____ / Married _____ (Date _____) / Widowed _____ (Date _____)
Separated _____ (Date_____) / Divorced _____ (Date _____)

Spouse Name _____ **Birthdate** _____ **Age** _____

Address (if different) _____

Telephone (___)_____ **SSN#** _____-____-_____ **Cell Phone** (____)_____

Employer/Occupation _____ **Work Phone** (___)_____

Children (names and ages) _____

_____

Parents _____ **Marital Status** _____

Address _____

_____ **Telephone** (___)_____

Brothers/Sisters (names and ages) _____

_____

Chief Complaint _____

_____

_____

Previous Evaluation/Treatment (where, when, who) _____

_____

Medications (Current/Past) _____

_____

Referred by _____

ADULT SYMPTOM CHECKLIST

In order to assist your clinician in the assessment process, please check any of the following symptoms that you have experienced within the last month.

_____ Irritability
_____ Sleep problems
_____ Worry a lot
_____ Tense
_____ Nightmares
_____ Poor appetite
_____Excessive appetite
_____Binge eating
_____Weight loss
_____ Crying
_____ Poor concentration
_____ Low energy
_____ Energy loss
_____ Hopelessness
_____ Fearfulness
_____ Lying
_____ Shyness
_____ Vomiting after eating
_____ Laxative use to control weight
_____ Trouble expressing feelings
_____ Trouble managing anger
_____ Physical violence

_____ Frequent sadness
_____ Recent loss
_____ Parenting problems
_____ Marital problems
_____ Sexual problems
_____ Family problems
_____ Work or school problems
_____ Hearing voices
_____ Do things over and over
_____ Trouble making decisions
_____ Drug usage
_____ Drink too much
_____ Family members drink
_____ Overspending
_____ Gambling
_____ Jealousy
_____ Hurts self
_____ Trouble with law
_____ Memory problems
_____ Feel someone is out to get you
_____ Feel taken advantage of
_____ Fears of _____

Name:_____ Date:_____

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Authorization for Release of Confidential Information

Part I

I, _____, give my consent for the release of confidential information concerning:

myself_____

Information to be released is limited to:

all findings_____

Disclosure of this information is for the purpose of:

evaluation or treatment_____

Information shall be exchanged between:

Karen L. Collier, LCSW_____

And the following person(s): (Ex: parent/guardian, spouse, primary care physician, etc.)

_____

_____

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment ends.

_____ _____
Date Signature

_____
Witness

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Authorization for Release of Confidential Information
Part II

I, _____, give my consent for the release of confidential information concerning:

___myself_____

Information to be released is limited to:

___my findings_____

Disclosure of this information is for the purpose of:

___evaluation or treatment_____

Information shall be interchanged between:

Karen L. Collier, LCSW_____

and:

YOUR INSURANCE PROVIDER_____

This consent may be revoked in writing at any time, but such revocation shall not be retroactive. This consent shall expire not later than one year after treatment ends.

_____ _____
Date Signature

_____
Witness

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Insurance Filing Requirements

Our current office policy requires payment at the time of service. We will file with all in-network managed care companies if indicated below. If you do not wish for us to file with your in-network insurance company, we will not backdate services if you later decide you want us to file. However, we will start filing your claims starting on the date you sign a new 'Insurance Filing Requirements' form allowing us to do so. If you have out-of-network insurance, we will not file for you but you are allowed to file on your own. Please note that insurance companies have limitations on which diagnoses and services are covered, and this information may be used in determining future insurance eligibility. **This means you are responsible for any payments not covered under your insurance policy.** Refer to your policy for these details.

- ☐ I do want this office to file with my in-network insurance company at this time
- ☐ I do not want this office to file with my in-network insurance company at this time
- ☐ I do not have health insurance at this time

_____
Signature of Authorized Party

_____
Date

_____
Witness

Revised 9/4/12

Please sign, date, and sign.

Do not fill out the rest.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $
29. AMOUNT PAID $	30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.