Letitia D. Brown, LCSW
Caring for Our Community

Intake Information

First Name: ______________________________ Last Name: ______________________________

Preferred Name: ______________________________ Preferred Pronouns: ____________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Cell/Home Phone: ____________________ Email address: ______________________

Marital Status: ____________ DOB: ____________ SS# ________________

Gender: ____________ Race/Ethnicity: ______________ Preferred Pronouns: __________

Primary Care Physician: ______________________________ Phone: ______________

Psychiatrist: ____________________________________ Phone: ______________

Parent/Guardian (if applicable): ____

Employer: ____

Primary Insurance: ______________________________ Policy #: ______________

Policy Holder Name: ______________________________ DOB: ____________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Briefly state your reason for Seeking Services: ____________________________________

____

Who should we thank for referring you to us? ____________________________________

Appointment Reminders

Please check the box with your preferred method to be noticed of your appointment date & time

Email and text are not secure forms of communication. Please do not email or text clinical information. I agree that appointment reminders are strictly a courtesy and understand missed appointments are my financial responsibility that will not be covered by my insurance. My signature below shows that I understand and agree with these terms.

☐ **Email Reminder:** ____

☐ **Phone Call: (____) ________-____________ Are Voicemails with Appt. Time & Date OK?: □ Yes □ No**

☐ **No Reminder**

______________________________ ____________________ __________

Client/Guardian Signature/Print | Relationship to Client | Date

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CLIENT CONSENT TO EXCHANGE INFORMATION

Insurance plans and managed care organizations (MCO) encourage the exchange of information between LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY and your Primary Care Physician (PCP) as well as other service providers to coordinate medical and psychiatric care.

Please make a selection below:

Consent to Exchange Information with your insurance carrier is required for coordination of benefits.

❐ I give consent for information regarding my treatment to be shared with:

Name of Insurance: ____ Policy#: __________________________

❐ I give consent for information regarding my treatment to be shared with my PCP/Referring Physician/Pediatrician/Therapist/Psychiatrist as follows:

Name of PCP: ____ PCP Phone: __________________________

Location: ____

Name of Therapist: __________________________________ Therapist Phone: _______________________

Location: ____

Name of Psychiatrist: __________________________________ Therapist Phone: ____________________

Location: ____

❑ I **do not** wish to have information regarding my treatment with this practice released to my PCP & other service providers.

Third Party Access

I authorize LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY to disclose current healthcare information with the family/others listed below.

____ ____

Spouse/Partner Parent

____ ____

Sibling Other

Client Signature: ____ Date: ________________

Parent/Guardian Signature: ______________________________________ Date: ________________

Letitia D. Brown, LCSW
Caring for Our Community

Authorization for Release of Information

I,__________________________, born on ____________ hereby authorizes Letitia Brown, LCSW to exchange information with:

Client name DOB

Name of individual and/ or organization:____

Address/Phone Number: ____

For the purposes:(specify) ____

This information includes (check all that apply):

☐ Medical Records
☐ Educational/Academic Records
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Court Report
☐ An on-going exchange of information
☐ Other (describe below)
☐ Neurological Evaluation
☐ Behavioral Reports
☐ Teacher Reports
☐ Treatment/Discharge Summary
☐ Substance Abuse Evaluation
☐ Past Services (Verbal Exchange or Reports)
☐ Urine Screen/Breathalyzer Results

____

This authorization is valid from ___________ to ___________, unless revoked by the undersigned.

Date Date

Consent Signature(s)

_______________________________________ ____________ ____________________________________ ____________

Above Named Client Date Parent/Guardian/Authorized Representative Date

Prepared and witnessed by: ____________________________

Staff Name

Revocation Signature(s)

I ___________________Revoke my consent for Letitia Brown, LCSW to exchange information with the above-named individual/organization as of this date _____________.

_______________________________________ ____________ ____________________________________ ____________

Above Named Client Date Parent/Guardian/Authorized Representative Date

Prepared and witnessed by: ____________________________

Staff Member

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

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CLIENT'S FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Client Name: ____ Date: ___________________

Insurance Company(s): ____

Assignment of Insurance Benefits

I hereby authorize LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY to furnish to the above-mentioned insurance company(s) with requested information.

I hereby assign to LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY, all money to which I am entitled for medical expenses related to the services rendered by my therapist, but not to exceed my financial obligation. It is understood that any money received from the above-named insurance company, over & above my obligation will be refunded either to me or my insurance company when my bill is paid in full. I agree to pay my co-payment/deductible at the time of service.

Self-Pay Rates

Assessment	**Rate**
• Intake Evaluation	$150.00
Outpatient Services	
• Individual Therapy	$105/45 min session
• Family/Marital Therapy	$175.00/45 min session
• Tele-Medicine (Therapy)	$125.00/45 min session

Please read then initial each statement below:

_______ I hereby agree it is my responsibility to advise LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY of any insurance changes in a timely manner. This will allow LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY time to obtain appropriate authorizations to be received prior to my appointment.

_______ Failure to notify LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY of insurance changes may result in a denial of services which will become your full financial responsibility.

_______ I hereby agree that I am financially responsible for all non-covered charges, at the rates listed above for Outpatient Therapy Services.

_______ I further agree, in the event of nonpayment, to bear the cost of collections and/or court cost & reasonable legal fees should this be required.

Letitia D. Brown, LCSW
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LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY accepts the following forms of payment: Credit/Debit Card, Health Spending, and Cash for in-person session.

Credit Card only for telehealth. PROCESSING FEE PAID BY THE CARDHOLDER) and

LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY charges a $35 fee for Denied Payments

____

Client Name (Print) Signature Date

____

Parent/Guardian Name (Print) Signature Date

Letitia D. Brown, LCSW
Caring for Our Community

Outpatient Therapy Cancellation & Missed Appointment Policy

In order to provide the best quality of care, we request that you provide LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY with **48 hours' notice** if you need to cancel or **reschedule an appointment.** This is inclusive of the **intake appointment and each subsequently** missed appointment. Failure to do so **will** result in a $95.00 fee per cancelled/missed appointment charged to the card on file.

If a patient arrives more than 10 minutes **late** for their **appointment**, the patient will be rescheduled for a later date, as required by insurance. This process also ensures patients that do arrive on time are seen in a timely manner.

Cancelling/missing three appointments without 48 hours' notice in a six-month period may result in termination of services. Please feel free to speak to your LETITIA BROWN, LCSW if you have any questions concerning this policy.

I have read the above statement and agree to abide by the policy as stated above.

Client Name (Print) Signature Date

Parent/Guardian Name (Print) Signature Date

Letitia D. Brown, LCSW
Caring for Our Community

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY is committed to protecting this medical information. Upon request, we will provide you a copy of the full HIPAA regulations.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment and health care operations–To coordinate your treatment within our agency.

For Payment. LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY may use or disclose medical information so that we can receive payment for the treatment services provided to you.

Substance Abuse Information. All medical information regarding substance abuse is kept strictly confidential and disclosed only in accordance with federal regulation (42 CFR part 2).

As Required by Law.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Client Signature: ____ Date: ______________

Parent/Guardian Signature: ________________________________ Date: ______________

Letitia D. Brown, LCSW
Caring for Our Community

FINANCIAL RESPONSIBILITY AND COLLECTION PRACTICES

In consideration of the therapy services provided by Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC., to, _________________________ (Name) I understand, acknowledge and agree:

1. **Financial Responsibility**: (i) to accept full financial responsibility for Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC., provided to me, and (ii) this financial responsibility includes, without limitation, co-insurance, deductibles and payment for services that are not covered by a health insurance plan, government agency, workers' compensation, or any other third party.

2. **Delinquent Accounts**: (i) for any delinquent accounts, to pay all costs of collection, including but not limited to, interest charges, collection agency fees, legal costs and attorney fees of thirty-three and one third present (33 1/3%) of the unpaid balance turned over for collection: (ii) to received, for collection purposes, auto-dialed and/ or artificial or pre-recorded message calls to my cellular telephone and to any telephone number provided by me to Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC. including but not limited to, calls from Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC. , and any account management company, contractor or debt collector retained by Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC. ; and (iii) that any lawsuit to collect sums owed by me may be brought in the courts in and for the City of Richmond, and I consent to jurisdiction thereof.

3. **Assignment of Benefits and Claims**: that I have assigned to Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC., and its agents, representatives, and delegees: (i) the right to file any claims to insurance or benefit companies for Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC. provided; (ii) any and all rights, benefits and claims for Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. provided under any policy of insurance (hospitalization, major medical, automobile, liability, workers' compensation, and any other); (iii) the right to directly received payments, proceeds or benefits from any claim that I, including payment of authorized Medicare/Medicaid benefits; (iv) the right to file any appeals or lawsuits on behalf of me, for payment for Letitia D. Brown, L.C.S.W. - Caring For Our Community, PLLC. ; (v) the right to use a copy of this authorization instead of the original; and (vi) the following:

   (a) To allow Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. to file claims on behalf of me: For cost of treatment and to receive payment and /or benefits.

4. Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. will not make a claim for payment that is more than I owe.
   Subsequent Services: This authorization includes any and all subsequent services rendered by Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC.

Letitia D. Brown, LCSW
Caring for Our Community

Maximum Charge amount: $350.00 (**No advance payments will be charged**, instead you are authorizing payment of any outstanding balances with the office of Letitia D. Brown, L.C.S.W.)

Effective date: ____________________ Expiration date: ___________________

I agree to allow Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. to charge my credit card:
____ Exp. __________/_______ CVV Code ____________________

for any amount not covered by insurance (up to the maximum charge amount), for all services provided by Letitia D. Brown, L.C.S.W. – Caring for Our Community, PLLC. to the patient(s) on or after the effective date and before the expiration date. I acknowledge that:

- My credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $350.00 has been charged to my credit card under this agreement, Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. will bill me directly for any amounts not covered by insurance.
- My credit card will be stored by Square Pay, Inc., a secure credit card processor affiliated with Lincoln Savings Bank that partners with Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. to collect payments.
- I will receive receipts detailing the amount charged.
- I may cancel this agreement at any time by contacting Letitia D. Brown, L.C.S.W. - Caring for Our Community, PLLC. any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be billed to me directly

Payment Information:

Card type: ____

Card number (last 4-digists): ____

Cardholder name: ____

Card holder email: ____

Cardholder signature: ____

Name: _____________________________________ Signature: ____

Letitia D. Brown, LCSW
Caring for Our Community

EMERGENCY CONTACT FORM

Emergency Contact Info:

Name____ Relationship____________________________

Address ____

City, State, ZIP ____

Home Telephone # _____________________________ Cell # ___________________________________

Name____ Relationship____________________________

Address ____

City, State, ZIP ____

Home Telephone # _____________________________ Cell # ___________________________________

Medical Contact Info:

Doctor Name. ____ Phone # ___________________________

Dentist Name ____ Phone # ___________________________

I have voluntarily provided the above contact information and authorize **Letitia D. Brown, L.C.S.W – Caring For Our Community, PLLC** and its representatives to contact any of the above on my behalf in the event of an emergency.

Signature ____ Date ___________________________________