2018 CLIENT PAPERWORK

Client's Name_____ DOB_____

Welcome to MindOasis, LLC, today's appointment is scheduled for 60 minutes. If you need to make changes to appointments or create new appointments, please do so through our online Therapynotes portal. **All payments are due at the beginning of the session.** We accept cash or credit card and do not accept checks. If the payment cannot be made, your appointment will be canceled, and you will be charged $25. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

TREATMENT AGREEMENT

The first session is the initial intake appointment to introduce you to our policies and procedures. We also want to gain understanding for the reason why you have chosen to start counseling and if the counselor you are placed with is an appropriate fit. At the end of the session it will be decided mutually, if continued sessions for healing will take place or if the you/client will be needing to be referred to another counselor to better meet your/client's needs. If the client and counselor decide to commit to working together, then it is encouraged that the next 3 sessions are immediately scheduled through the scheduling portal: https://www.therapyportal.com/p/mindoasis/

Most treatment plans require 2-4 sessions monthly for your healing transformation to be successful and long lasting. We believe in working intensely to make the most effective progress. After 10-20 sessions, there should be significant progress towards the initial goal, given client participation in sessions and outside of session as well as the amount of trauma/problems that have been experienced or still being experienced. If progress is not made, the treatment plan will be reevaluated and a decision for continued treatment or termination will be made. A huge part of the journey is that the client follows through with the strategies outside of counseling appointments and focuses on treatment goals/objectives during sessions.

All sessions should be scheduled online through your mobile device/computer by going to www.mindoasis.me or at the beginning of the session. The online option allows you to schedule or cancel and appointment at any time of day. If two months go by without an appointment, we will terminate your treatment plan. If you decide to resume treatment after termination, you will need to do so as a new client intake.

Signature(s)_____Date_____

This document is intended to inform you of our policies, State and Federal Laws and your rights.

MindOasis LLC counseling

FINANCIAL/INSURANCE ISSUES

Most clients have a deductible that must be met annually before the insurance company will pay any benefits. This means the client is responsible for the full fee of the session until the deductible is satisfied. Your explanation of benefits will state how much you owe for each session, and may take up to 2 weeks after the first session to process. All clients must pay the full contracted insurance fee until your deductible is met, unless your insurance card shows a copay on the front of it. You may check coverage of the billed codes CPT Codes 90791 (Initial Intake Form) 90834 (45min) 90837 (60min). If your insurance company denies payment (outside of not meeting the deductible) or does not cover counseling, you can continue counseling by paying the self-pay rate of $150. However, you must pay for the entire outstanding balance before services are resumed. All balances of $50 or more must be paid in full before another session can be scheduled. Appointments will be cancelled until paid. This means, you will lose your scheduled appointments.

I agree to give MindOasis, LLC permission to bill my insurance company, PPO or HMO. I authorize MindOasis, LLC to charge my credit card above for agreed upon copays, fees for services until my deductible is met, fees for services that insurance does not cover, cancellations without 24hr notices will be charged $85 and any product purchases (Shirts, Mugs, Essential Oils, etc.). I understand that my information will be securely saved electronically for future transactions through TherapyNotes. This also allows more time for counseling instead of focusing on payment at each session.

At my first session, I understand it is required that I pay the minimum of $200, until my insurance has responded with client's EOB/client's responsibility of payment. I understand that my follow up sessions (under two weeks after initial session), I will continue to pay $150 until my insurance company has responded with the Explanation of Benefits/client's responsibility of payment. (This does not apply to EAP). Every insurance company has a different payment rate. MindOasis, LLC can provide more details at time of session.

I understand that if I need to cancel or reschedule an appointment, 24 business hours with advance notice is required, otherwise I will be billed at $85 to cover the counselor's time. There will be a two-time exception within a 12-month period, no exceptions. I acknowledge that I understand the insurance and self-pay option and agree to follow the agreement listed above.

We sincerely appreciate your cooperation and encourage you to ask questions regarding insurance, fees, balances or payments. You may have a copy of this form if requested. Please pay for services using cash or credit card, no checks. If a parent is unable to attend services that their child is receiving, please send cash with the child or pay invoice online within 2 hours of the session or future appointments will be cancelled if balance exceeds $50.

If a letter for attorney, doctor, DCFS is required you will be charged $85 flat fee for each letter. Any court or school appearances will be charged $200 per hour private pay fee directly to your credit card.

Signature(s)_____Date_____

COORDINATION OF TREAMENT

Primary Physician's :_____

ADDRESS:_____

PHONE NUMBER:_____

Psychiatrist:_____

ADDRESS:_____

PHONE NUMBER:_____

OBGYN's:_____

ADDRESS:_____

PHONE NUMBER:_____

It is important that all health care providers work together. As such, I give MindOasis, LLC permission to communicate with my physicians and psychiatrist. I understand that my consent is valid for one year. I understand that I my authorization maybe revoked at any time.

____ You may coordinate my treatment needs and concerns with my physicians.

____I decline to allow MindOasis to coordinate my treatment for optimal care.

Client's Name_____ DOB_____

SIGNATURE(s)_____DATE_____

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law.
In the unlikely event that I am unable to provide ongoing services there will be another counselor to continue services and will maintain your records for a period of 7 years. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the 309.857.6399. If no call is received within 15 minutes or you cannot wait, the client or guardian understands that they are to contact the emergency services in the community (911) or local emergency room for those services. MindOasis, LLC will follow up those emergency services with standard counseling and support to the client or the client's family. **Text messages and social networking sites are not 100% confidential, and we may not be able to respond immediately. Social Networking sites may not be used for counseling/emotional concerns nor cancelling or scheduling appointments. MindOasis, LLC will not return calls/texts immediately unless it is an emergency. MindOasis, LLC responds within 48 business hours.**

Signature(s)_____Date _____

CONSENT FOR TREATMENT FOR MINOR CHILDREN

I consent that _____ may be treated as a client at MindOasis, LLC. It is understood that children over the age of 12 have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing. If parents are divorced, we require divorce decree and may need both parent's signatures if there are visitation rights.

Parents Name_____
DOB_____
Parents Name_____
DOB_____

Signatures of Both Parents_____Date_____

Release of Information/Permission
(Example: Someone you allow to be present in your session, Employer, Lawyer, Previous Counselor)

I, _____,date of birth,_____ authorize the release of copies, or allow inspection of, mental health records for the above named individual.

I give MindOasis, LLC permission to release information about _____ DOB _____ to _____

The information and/or records to be disclosed include:

- Mental Health Evaluations
- Intake & Discharge Summaries
- Diagnosis
- Complete Medical Chart
- Treatment Plan
- Summary of Treatment to Date
- Progress Notes/Treatment Records
- Billing Records
- Conversation between above parties to discuss case/treatment/participate in session

This information is being released for the purpose of:

- Quality of care
- Clinical/Diagnostic Evaluation
- Treatment Planning
- Report Preparation
- Other:_____

Expiration of Consent: This consent shall expire automatically upon the fulfillment of the purpose stated herein. Additionally, this consent will expire on _____, 20_____.

Right to Revoke: This release is voluntary on my part. I may take back this consent at any time, except to the extent that action based on this consent have already been taken.

Authorization: I hereby authorize the information described above to be released.

_____ _____

Signature of patient Printed name of patient Date

_____ _____

Signature of Witness Printed name of Witness Date

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS

PLEASE GIVE MINDOASIS, LLC A COPY OF YOUR INSURANCE CARD and ID

- I am self-paying ($200 for initial session and $150 for 60 min continuing sessions)_____
    - I am using my Employee Assistant Program First (yes or no)_____
- Any sessions more than 60 minutes, I am responsible for $75 self-pay for every 30 minutes.

Name of Person the insurance plan is under (this may be yourself, spouse or parent)

_____

That Person's Date of Birth _____

Their Contact Number_____

Their Address_____

Name of Client _____

Client's Address _____

D.O.B._____ Age_____

Client's Phone #_____

Client's Email_____

Do you get an authorization or a referral from a doctor (Usually required for HMO)? _____

My insurance will cover the following codes: CPT Codes (Call insurance now to find out coverage if you have not already done so): 90791_____90837_____90847_____

Patient's Co-pay_____

Patient's Deductible for In Network Behavioral Health Office Visits _____

I understand that I am responsible for knowing my insurance benefits. I am financially responsible for my deductible and for treatment that is not covered through my insurance policy. If my insurance does not cover services I will fully cover the incurred fees.

Signature:_____
Date:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I have read and received a copy of MindOasis, LLC Notice of Privacy Practices and Client Rights document.

May we contact you at home/cell? _____ at what number _____

May we contact you at work? _____ at what number_____

May we contact you through email? _____ Email address_____

May we contact you through facebook?_____(for business purposes only)

Signature(s)_____Date_____

HIPPA 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: October 1, 2015

MindOasis, LLC has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes our policies related to the use and disclosure of your healthcare information.

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 allows 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.

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.

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 does 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 Illinois State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. 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. Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

Signature(s)_____Date_____

Client Rights

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 gave us when you scheduled your appointment. Sometimes we may leave a message on your voicemail. You have the right to request that our office communicate with you a different way. You have the right to decline appointment reminders.

Right to release your medical records. You may have consent in writing to release you records to others you have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical records. You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstances we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a fee for the costs of copying, mailing, and supplies.

Right to add information or amend your medical records. If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will decide on your request within 60-90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, your have the right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you may contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for you request.

Right to an accounting disclosures. You may request an accounting of any disclosure, if any, we have made related to your medical information, except an information we used for treatment, payment, or health care operation purpose or that we share with your family, or information you have use specific consent to release. It also excludes information we were required to release.

Right to request restrictions on uses and disclosure of your health information. You have the right to ask us for restrictions on certain uses and disclosure of your health information. This request must be in writing and submitted to the office manager. However, we are not required to agree to such a request.

Right to complain. If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the US department of Health and Human Services. And individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy. You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

Print Name: _____ Date: _____

Signature_____ Date: _____

Updates as of 04/17/2018

As of May 17, 2018 the self-rate fee is $150 per 60 minutes in order to be compliant with insurance contracts.

All Hypnotherapy sessions are performed by Amy Fischer, LCSW and take 90 minutes to complete. The self-rate fee for the service is $200. Clients who use insurance will still be responsible to pay the additional 30-minute fee out of pocket $75. (This must be scheduled in person with Amy or through emailing amy@mindoasiscounseling.com)

EMDR sessions can be performed in 60 minutes but the full 60 minutes is needed for a complete session. If the client needs talk therapy time as well, the client should schedule a 90-minute appointment. The client will be responsible for $75 self-pay rate for the additional 30 minutes.

We are now offering the Trim Life Hypnotherapy Group and are taking down names of those who are interested. The cost is $350 for the 6 weeks and this includes all of the materials that you will receive. Please email amy@mindoasiscounseling.com or tell your therapist you are interested. The class will take place on either Monday evenings or Thursday evenings (Please give your preference).

Client Name_____

Signature_____

Date_____