Masino
Mental Health
Services
1008 Airport Rd, Suite D
Destin, Fl 32541
850-424-5210 Office 850-424-3220 Fax
info@masinomentalhealth.com

First Name | **Middle Name / MI** | **Last Name** | **Date**

Patient Address Line 1 | **Patient Address Line 2**

City | **State** | **Zip**

Home Phone | **Cell Phone** | **Work Phone**

Social Security Number | **Date of Birth** | **Email** | **Marital Status**

Presenting Problem

Responsible Party (*complete this portion if patient is a minor*)

First Name | **Middle Name / MI** | **Last Name**

Address | **City** | **State** | **ZIP**

Home Phone | **Cell Phone** | **Work Phone**

Social Security Number | **Date of Birth** | **Email Address** | **Marital Status**

Primary Insurance Name | **Primary Subscriber ID** | **Policy Holder's Name** | **Primary Group No.**

Secondary Coverage we only bill secondary with Medicare being primary

Secondary Insurance Name | **Secondary Subscriber ID**

TRICARE FAMLIES

Sponsor's Social Security

.

○ Prime - Active Duty ○ Prime - Retired ○ SELECT - Active Duty ○ SELECT - Retired

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I AGREE TO THE FINANCIAL TERMS AND CONDITIONS FOR MASINO MENTAL HEALTH

Appointment Cancellation Policy:
Staff members at Masino Mental Health Services, Inc. are committed to our patients and continue to accept new patients. A missed appointment is a missed opportunity and delay for another patient. Therefore, we require a credit card number to hold appointment times. **By providing this information to be added to your account and/or signing this agreement, you agree to the terms and conditions of charges and/or outstanding balances that are patient responsibility and use of any active credit card on file. You agree that this will act as your signature for payments to be processed and approved.** Any voicemails or emails after hours will be considered next business day.

PRACTITIONERS CANCELLATIONS WAIT TIME AND NO-SHOW Policy:
Staff members at Masino Mental Health Services, Inc. are committed to our patients. Multiple reminders are sent out via text or email from our automated system. This system also tells us when a patient received the reminder and at what time the responded to it. **Practitioners expected wait time for patients to arrive at the clinic or to arrive on Telehealth will be 15 minutes.** Please make sure you call if there are any issues that we can assist with and notify the practitioner if these things happen.

If a patient is later than 15 minutes the appointment will be canceled, and a NO SHOW Fee added. If the appointment is a **NO SHOW** a **NO SHOW FEE** will be added to the missed appointment. A missed appointment is a missed opportunity and delay for another patient. Therefore, we require a credit card number to hold your appointment time. If for any reason you are unable to keep your appointment, please call at least one business day in advance to allow us to schedule another patient. Any voicemail or emails after hours will be considered the next business day. **A $100.00 fee will be applied otherwise.**

If more than THREE sessions are missed OR CANCELLED, continued services will be re-evaluated AND PRESCHEDULED APPOINTMENTS WILL BE REMOVED FROM THE PRACTITIONER CALENDAR. We appreciate your assistance in helping us serve you better by keeping scheduled appointments.

Testing Appointment and Cancellation Policy:
The practitioners at Masino Mental Health Services, Inc. schedule up to 4 hours to perform testing for a patient. If for any reason you are unable to keep your appointment, please contact us at least 72 hours prior to the scheduled testing date. We do understand emergent issues and each practitioner will address those items on a per client basis. **A credit card is required to be on file for all testing. Testing Cancellation fees are as follows:**
This is nonnegotiable: $165 Practitioner Cancellation Fee $120 Testing Cancellation Fee

Therapy Cancellation Fee Procedure:
These fees of $100 will be applied if the appointment is a No show, last minute cancellation by patient, or canceled less than 24 hours for any therapy appointment. Patient will receive 3 appointment reminders for their appointment. Reminders are sent via text and or email. The scheduling software tracts when they are sent to patient and when a response is processed back from the patient to facilitate proper communication for appointments. Messages left on our answering service or machine will be considered as the next business day. The patient appointment will NOT BE CONFIRMED until the credit card is on file. Messages left after hours via voicemail or email will be considered next business day.

Testing and Feedback Payment Policies:

We will do our best to obtain authorizations for all testing and feedback codes. If insurance applies items to the deductible/copay/coinsurance or DENY services, this will be patient responsibility**. All procedures for testing and feedback will be paid in full prior to the release of the final report.** These reports take upward to 4 hours to prepare, and this is the financial policy to have the total testing and feedback paid PRIOR to the release of the final report. Feedbacks are typically scheduled on Thursday or Fridays. **Our billing department will attempt to process the estimated or total payment the MONDAY prior to your feedback date. IF the payment does not process Billing will contact for payment and/or cancel the Feedback appointment until payment is made.** At that time, we will reschedule the feedback appointment which could be upwards to 3 weeks later than your original date of your feedback. **By providing this information to be added to your account and/or signing this agreement, you agree to the terms and conditions of charges and/or outstanding balances that are patient responsibility and use of any active credit card on file. You agree that this will act as your signature for payments to be processed and approved.**

Phone Call Fees

Calls to the client: This one is more straightforward, whether the client is paying out of pocket or using insurance. Therapists will charge for phone calls with the client if the conversation exceeds 10 minutes Calls to family members: Sometimes therapists need additional information from family members, especially if the client is a child.

Case consultation: A documented meeting of at least 15 minutes' duration, either in person, by telephone, or mail between the treating provider and other behavioral health/medical clinicians or physicians, concerning an individual who is a client of the behavioral health provider (in-other-words, case consult is between providers).

Collateral contact: This is a call to a person with a source of information that is knowledgeable about the client's situation and serves to support or corroborate information provided by a client. That person would include, but is not limited to, school and day care personnel, state agency staff, human services agency staff, court appointed personnel, religious/spiritual leaders, and/or other community resources (in-other-words, collateral contacts are between anyone else in the client's life who is not a provider).

Billing

Payment for all client statements is due in full upon receipt. Payment arrangements can be made in advance for some account. Balances owed will be charged weekly up to $300 per payment on the credit card on file until balance is paid in full. **Completion of any testing or feedbacks will NOT be concluded until balances are paid in full**. By signing this agreement and/or providing a credit card on file, you agree to the terms and conditions of any outstanding balances that are patient responsibility and use of credit card on file. Your signature and/or by providing the credit card on file acts as your signature for payments to be processed and approved. Some benefit plans often have limits on Psychological Testing. Some plans limit the maximum benefit payable per year or thenumber of units that will be payable. If your Psychological testing/Neuro Psychological testing is not covered or exceeds the limits you will be balance billed according to the contracted rates of your insurance company for any unpaid units. ***You will be billed for claims that exceed the plan limits, up to the fee schedule amount for the services rendered.***

Declined Payments on Payment Plans, Checks, and unpaid account with overdue balances longer than 60 days:

A $60.00 service fee will be added to your account for each 60-day passed due, declined payment, or RETRURNED CHECK per month.

My signature below and/or by providing credit card on file acknowledges that I have read, fully understand, and agree to all parts of the financial policy of Masino Mental healthServices, INC. I also understand that my account may be turned over to a collection agency if it becomes delinquent.

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service, and it will become a patient responsibility.

16-digit credit card #	**Name as it appears on credit card**	**Exp. Date**	**CVV**
_____		_____	_____

Authorizing Signature: _____

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Informed consent for Mental Health Evaluation / Treatment

I hereby voluntarily consent to a mental health evaluation including psychological testing. I understand that these are primarily non-invasive, pencil and paper tests given for my benefit to better understand my health care condition. I know that the results and issues discussed are private and cannot be communicated to anyone else without my consent.
(This is consent for your initial evaluation.)

Initial

_____

I hereby voluntarily consent to mental health treatment or rehabilitation. I understand that this primarily includes psychotherapy (talk therapy), either individually or with my family. I know that the issues I discuss are private and cannot be communicated to anyone else without my consent.
(This is consent for your treatments after your initial evaluation.)

Initial

_____

I have been requested to participate in a court-ordered psychological evaluation/treatment program. The results of the evaluation or treatment progress will be reported to the person listed below.

Reported To:

_____

Initial

_____

I voluntarily consent to the following Testing/Treatment:
(This is consent for psychological testing for yourself.)

I voluntarily give consent for my child to receive the following Testing/Treatment:
(This is consent for psychological testing for your child.)

Initial

_____

Client/Patient is unable to consent due to:

- [ ] Client/Patient is a minor
- [ ] Client /Patient is unable to consent because (reason below)

Reason Client is unable to consent **Relationship to Client/Patient**

_____ _____

My relationship to the client/patient is listed above, and I have signed this consent on his/her behalf.

Parent/Guardian Signature

Date

_____

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Notice to Patients Regarding Privacy of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that this practice provide you with this notice regarding Personal Health Information (PHI). Each time you visit a healthcare provider, a record of your visit is mad. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- basis for planning your care and treatment
- means of communication among other health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Protected Health Information (PHI) is any health information created or received by your health care provider that contains information that may be used to identify you, such as name, address, telephone numbers, and account numbers, or your condition. It includes written or oral health information that relates to your past, present, or future mental health; the provision of health care to you; your past, present, or future payment for health care.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations

Our Responsibilities:

This Practice is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Options

Your Protected Health Information (PHI) may be used and disclosed by this Practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be in writing, electronically, by facsimile, or orally. Additionally, this Practice may also use your PHI to remind you of an appointment, inform you of potential treatment alternatives, and inform you of health-related benefits or services that may be of interest to you.

Other Uses or Disclosures Permitted Without Authorization

In addition to treatment, payment, and health care operations, our Practice may use or disclose your PHI without your permission or authorization in certain circumstances including:

- When legally required to comply with any Federal, state, or local laws that involve disclosure of your PHI
- When there are risks to public health as permitted or required by law
- To report abuse, neglect, or domestic violence if it is believed that the patient is a victim

- To conduct health oversight activities such as audits, or civil, administrative, or criminal investigations, proceedings or actions
- For judicial and administrative proceedings authorized by an order of a court or administrative tribunal
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation in such cases as identification, determination of cause of death, and/or performance in the medical examiner's duties authorized by law
- For research purposes if such use has been approved by an institutional review board or privacy board
- For specified government functions as authorized by HIPAA privacy regulations
- In correctional institution situations when information necessary for your health, and the health and safety of other individuals

If you have any questions or would like additional information you may contact the Privacy Officer at the following address:

Masino Mental Health Services, Inc.
1008 Airport Rd., Ste. D
Destin, FL 32541
ATTN: Privacy Officer

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health Services. There will be no retaliation for filing a complaint.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

Signature of Patient or Legal Representative

Date

If signed by legal representative,
relationship to patient

Distribution: original maintained in patient record copy provided to patient upon request

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Telemental Health Services Informed Consent

This informed consent form is to give you information about Masino Mental Health Services Inc telemental health services and serves as an addition to MASINO MENTAL HEALTH SERVICES INC Informed Consent Form.

In Florida, Telehealth refers to the use of telecommunication technology by a provider to provide care services. This provision of services may consist of audio conferencing or video conferencing through a personal laptop, computer with a webcam or other smart device.

MASINO MENTAL HEALTH SERVICES INC partners with the secure and private Zoom or Web Ex platform to execute telemental health services. There are always risks with telemental health services, including, but not limited to, the possibility that: the transmission of your confidential information could be disrupted or distorted by technical failures or interrupted by unauthorized persons, and/or the electronic storage of counseling information could be accessed by unauthorized persons. MASINO MENTAL HEALTH SERVICES INC counselors typically provide services from our offices; however, during rare situations, clinicians may work from home. They take reasonable efforts to operate in a secure and confidential space, minimizing interruptions and distractions.

Client Eligibility & Responsibilities:
To engage in services, you must physically be in Florida, except for crisis consultations; if you are physically located outside of Florida, you must immediately notify the counselor. You will need a device with a microphone, speakers, and a camera for audio and/or videoconferencing. You will need a reliable internet connection and the ability to have space that ensures your privacy (you are alone in the room), has sufficient lighting, and is free from distractions or interruptions. You should be dressed if you were attending an in-person face to face session. You will meet with your counselor only at the agreed upon time, and you may not record telemental health services. Your sessions with the MASINO MENTAL HEALTH SERVICES INC counselor will only be recorded with your written consent.

Appointments and Fees:
MASINO MENTAL HEALTH SERVICES INC financial policy applies to all types of services, including telemental health services. Please see our financial policy for more information. Please note that if you will not be able to attend an appointment, you will need to cancel or reschedule prior to 24 hours of the appointment to avoid a fee.

Confidentiality and Record Keeping:
As with all MASINO MENTAL HEALTH SERVICES INC services, electronic records of services will be maintained by MASINO MENTAL HEALTH SERVICES INC. Your counselor and MASINO MENTAL HEALTH SERVICES INC will protect the confidentiality of clients and the content of telemental health sessions. You may withdraw or withhold consent from teletherapy services at any time. You may also terminate telemental health treatment at any time. Your private information will not be released unless required by law:

- When doing so is necessary to protect you or someone else from imminent physical and/or life- threatening harm.
- When a client lacks the capacity or refuses to care for themselves, and such lack of self-care presents substantial threat to their well-being.
- When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected. Examples of abuse, neglect, or exploitation include, but are not limited to, violence towards a minor, a minor witnessing violence or being in the presence of violence, drug use in front of or while caring for a minor, or financial exploitation of an elder adult. Examples may also include incidents of past abuse, including those described above.
- When a client pursues civil or criminal legal action against the MASINO MENTAL HEALTH SERVICES INC or its staff or when a client makes a complaint to a Professional Board about a counselor.
- When a client is involved in a legal proceeding and there is a court order for the release of the client's records.
- In accordance with the Patriot Act, Masino Mental Health Services Inc. may disclose a client's mental health information to authorized federal officials, who are providing protective services to the President of the United States and other important officials, or to authorized federal officials who are conducting national security and intelligence activities. By law, MASINO MENTAL HEALTH SERVICES INC cannot reveal to the client when we have disclosed such information to the government.

You may also release your private information by completing a release of information form. If you have any questions about confidentiality, please ask your counselor. You are responsible for maintaining confidentiality on your end of the electronic communication (i.e., being in a private space while audio- or videoconferencing).

Participation in telemental health treatment requires that MASINO MENTAL HEALTH SERVICES INC provides minimal identifying information to be shared with Zoom or Web Ex. including your name, e-mail address, and telephone number. As a service provider, Zoom and Web Ex adheres to strict confidentiality laws. Zoom and Web Ex will collect information so that they can provide technical support and to facilitate interaction with your MASINO MENTAL HEALTH SERVICES INC counselor. The data that Zoom or Web Ex keeps will be used in evaluating and improving the service.

Emergency/Crisis Situations:
In any mental health treatment or counseling a small number of people do not respond or improve. We depend on you to follow the procedures below if you are in crisis:

- If you are in distress or crisis and need to speak to a mental health counselor during our business hours you may call MASINO MENTAL HEALTH SERVICES INC office to speak to the counselor on duty or seek same day appointment.
- If you are in imminent danger to yourself or others, call 911 or have someone take you to an emergency room at the nearest hospital.
- If we are concerned about you, if we lose contact with you, or if you fail to show for a scheduled audio- or videoconference, we will contact you by phone to check on your wellbeing. In addition, if you are showing signs of being in real trouble, we require that we have permission to contact someone to ensure your safety. Consistent with national standards, we require three levels of contacts to be identified to participate in online services:

1) A close personal contact such as a parent, spouse, sibling, or friend with whom you have on-going contact

Next of Kin Contact Name _____

Next of Kin Relationship to Patient _____

Next of Kin Home Phone _____

2) A professional contact such as a primary physician or friend.

Professional or Personal Contact Name _____

Relationship _____

Phone _____

3) The office or agency that does crisis well-being checks in your community (typically a 24-hour crisis service or the police department).

The following statements are also important for safety planning. Please read and initial:

If I show signs of deterioration or distress that indicate that I may be in danger, I grant MASINO MENTAL HEALTH SERVICES INC and my therapist permission to contact me by phone and to leave a message.

Initial _____

If I show signs of deterioration or distress that indicate I may be in danger, and I fail to respond to phone messages, I grant MASINO MENTALHEALTH SERVICES INC permission to contact those individuals listed above to verify my well-being.

Initial _____

If I show indicators that I may be at serious risk for self-harm or harm to others, I understand that MASINO MENTAL HEALTH SERVICES INC is required to contact the crisis response contact above to ensure my safety. This may also take the form of a wellbeing check conducted through my local police department.

Initial _____

If I show indicators that I may be at serious risk for self-harm or harm to others, I understand that MASINO MENTAL HEALTH SERVICES INC is required to contact the crisis response contact above to ensure my safety. This may also take the form of a wellbeing check conducted through my local police department.

Signature of Person Consenting to Treatment