NEO
Counseling Services

9930 Johnnycake Ridge Rd 4F
Mentor, OH 44060
(440) 579-5100

Client Information

Name _____ Parent or Guardian (if applicable) _____

Address _____

Cell Phone _____ Work Phone _____ Other Phone _____

Date of Birth _____ Age _____ SS # _____

Email Address: _____

Occupation _____ Employer _____

Marital Status _____ Partner's Name _____ Age _____ Employer _____

Have you ever been in counseling before? YES NO

If yes, when, with whom, & how long _____

List current medications _____

Allergies _____

Persons to contact in case of emergency _____ Relationship _____

Cell Phone _____ Work Phone _____ Other Phone _____

Insurance Name_____

Policy Number_____ Group ID_____

Policy Holder Name _____ Policy Holder Date of Birth _____

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Financial Agreement

NEO Counseling, LLC has established a fee of $150 for the initial therapy session and $90-150 for all other therapy sessions. We have contracted with most insurance companies as Preferred Providers. We try to be clear about our financial arrangements in spite of the complexity and the fact that we cannot guarantee the accuracy or thoroughness of the information provided by your insurance or managed-care company. Please review your policy so that you are clear how it works by contacting your health provider directly.

Client: Please Verify This Insurance Information

At the time you are beginning therapy, your company has indicated that you have insurance with _____, with a $_____ deductible, of which $_____ has been met; a co-pay of $_____ and/or co-insurance of _____%. You have _____ sessions per year.

In those situations, in which you are required to do pre-certification, you must complete this task prior to the end of the first appointment; or else you will be responsible for payment of the session. Payment for deductibles and co-pays must be paid at the time of each session. If we do need to bill you, we expect to be paid promptly. Since we discount our rates, we are unable to extend credit. We accept cash, check, Visa, Master Card, American Express or Discover. In the event that your account becomes delinquent, and you have made no payment arrangements, we reserve the right to use an independent collection agency to procure payment.

Since we sell both our time and our expertise to you, we need you to take responsibility for canceling appointments at least 24 hours in advance so that we can fill your appointment time if you are unable to use it. Most insurance companies do not pay for last minute cancellations or miss appointments, so payment for this time is your responsibility. In the event of a true emergency, your therapist will be willing to negotiate this fee with you.

By signing below…

- I authorize you to provide behavioral health services requested.
- I agree to the payment plan above and I understand that I am financially responsible for all charges if not paid by my third-party payer within in 90 days.
- I authorize the release of information to my managed care, my insurance company for payment of benefits to *NEO Counseling, LLC.*
- I agree to pay all bills, or make a payment plan, within 30 days of receipt of a bill. If not, counseling sessions with be placed on hold

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed Name Relationship to client

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Cancellation Policy

- Cancellations must be made at least 24 hours prior to scheduled appointment, or clients will be charged for the full cost of the missed session.
- Clients arriving more than 15 minutes past the set appointment time are considered “no-shows” and will be charged for the full cost of the missed session.
- All cancellation policies take into consideration that emergencies, unexpected illness, and transportation or traffic delays can occur. Within reason, these will always be accommodated without penalty.

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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.

Our Commitment To Your Privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see end of form) about any questions or problems.

How We Use and Disclose Your Protected Health Information with Your Consent

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing Your Health Information Without Your Consent

There are some times when the laws require us to use or share your information. For example:

- When there is a serious threat to you or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
- When we are required to do so by lawsuits and other legal or court proceedings.
- If a law enforcement official requires us to do so.
- For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your Rights Regarding Your Health Information

- You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- You can ask us to limit what we tall people involved in your care or the payment for your care, such as family members and friends.
- You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
- If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
- You have the right to get a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy from the privacy officer.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can also file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws if our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

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Client Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third-party payers.
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed Name Relationship to client

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court-ordered, I will have to answer to the court).

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment.

By signing, I agree to the above:

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed Name Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

_____

Signature Therapist Date

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and *NEO Counseling Services, LLC.* When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it by writing to *NEO Counseling Services, LLC*. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____
Signature of client or personal representative Date

_____ _____
Printed name of client or personal representative Date

_____
Description of personal representative's authority

_____ _____
Signature of authorized representative of this office Date

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Client Email/Texting Informed Consent Form

1. Risk of Using Email/Texting

   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

   - Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   - Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   - Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   - Employers and on-line services have a right to inspect emails sent through their company systems.
   - Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
   - Email and texts can be used as evidence in court.
   - Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the Use of Email and Texts

   The therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. The therapist is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misconduct. Clients/parent/legal guardians must acknowledge and consent to the following conditions:

   - Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   - Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   - All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
   - Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   - Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   - Provider is not liable for breaches of confidentiality caused by the client or any third party.
   - It is the client's/parent's/legal guardian's responsibility to follow up and/or reschedule an appointment if warranted.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email or text.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of client or personal representative Relationship to client

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Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits of practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist things will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse audio or video recording of sessions (but you may ask for it if you wish).
- Refuse to answer any questions or give any information you choose not to answer or give.
- Know if your therapist will discuss your case with others (for instance, supervisors, consultants, or students).
- Ask that the therapist inform you of your progress.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of client or personal representative Relationship to client

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TELEHEALTH CONSENT FORM

I, _____ hereby consent to engage in Telehealth with _____
Patient's Name Therapist Name & Credentials

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communicationsvia Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information couldbe accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur viaTelehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer.
7. In-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
8. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
9. I understand that some Telehealth platforms allow for video or audio recordings and thatneither I nor my therapist may record the sessions without the other party's written permission,
10. I have discussed the fees charged for Telehealth with my therapist and agree to them and I have been provided with this information.

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11. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Patient's Signature _____ Date _____

Patient's Printed Name _____

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy servicesfrom Therapist via Telehealth.

Therapist's Signature _____ Date _____