Relationship ReDiscovery Center LLC
Insurance Contact Guidance

Todays medical systems are very confusing and can be challenging to navigate. Hopefully, this guidance and the attached work sheet will help you to obtain needed information to begin your counseling and to determine the approximate cost of these services. Insurance companies do state that they cannot accurately determine your final cost until the bills have been submitted and processed. The following steps are likely to result in an estimate. The key words and phases noted in bold type will help you, as will patiences throughout your call.

Step 1: Please call your insurance company before coming into your first appointment. Your insurance card will list the needed customer service phone numbers. If multiple numbers are listed call the number for "Behavioral Health" or "Mental Health". Follow all the prompts until you are connected to a person. Let them know you are a member calling about **"routine outpatient mental health counseling services"**. Some of the following questions maybe answered before you ask. Note all answers on the attached Insurance Work Sheet.

Step 2: Verify in-network status of your provider by asking, **"Is Bill Gould LCPC an in-network provider? His address is 444 Main St, Lewiston, Maine."**

Step 3: Ask, **"Is preauthorization required for routine outpatient mental health counseling services"**. If the answer is yes, you may be asked a few questions and provided with an authorization number, the number of allowed sessions, a start date and ending date. If no preauthorization is required move on to the next step.

Step 4: Ask, **"Do I have a deductible?"** If they answer yes … Ask, **"What is the remaining balance?"** You may be given figures for both in-network and out-of-network.

Step 5: Ask, **"What is my co-pay or co-insurance?"** which can be set dollar amount or a percentage rate.

Step 6: Even if you are not invested in TeleTherapy, you still should ask should the need arise in the future. Ask, **"Does my plan cover Video and or phone mental health counseling?"**

Step 7: This step only applies if you are coming with your partner. In such cases it is important to ask your insurance company: "Does my insurance policy cover "Family Counseling"? Please note it is important to use the term "Family Counseling"; if you use the terms "Marriage Counseling", "Couples Counseling" or "Relationship Counseling" most insurance companies will state that they do not cover those services and may not mention if they cover "Family Counseling", unless you ask. If your insurance company does not cover "Family Counseling", alternative service and billing options will be explored and defined in our first session. It may be helpful to complete an Insurance Work Sheet for each of you as appropriate.

This call to your insurance company will not result in an estimated cost per a session. The information you provide on the attached Insurance Work Sheet will make it possible for us to determine an estimated session cost after reviewing our historical data. Please bing in your insurance card and the completed Insurance Work Sheet to your first session.

PLEASE FORWARD A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

I look forward to meeting you soon.

Thank you.
Bill

Relationship ReDiscovery Center LLC
Insurance Work Sheet
Please print clearly

Client Name: _____ Date of Call: _____

Step 1: Please call your insurance company and let them know you are a member calling about **"routine outpatient mental health counseling services"**. Fill in the blanks as appropriate.

Step 2: Ask, **"Is Bill Gould LCPC an in-network provider? His address is 444 Main St, Lewiston."**
Bill is …. _____ In-Network or _____ out-of-network

Step 3: Ask, **"Is preauthorization required for routine outpatient mental health counseling services"?**

_____ No preauthorization is required or _____ Yes preauthorization is required

If yes …. Preauthorization number: _____

Number of preauthorization sessions: _____

Preauthorization start date: _____

Preauthorization end date: _____

Step 4: **"Do I have a deductible?"**

In-Network Deductible amount: _____ In-Network remaining Balance: _____

Out-Network Deductible amount: _____ Out-Network remaining Balance: _____

Step 5: **"What is my co-pay or co-insurance?"** Co-pay/Co-insurance _____

Step 6: Ask, **"Does my plan cover TeleTherapy and or phone for mental health counseling?"**

TeleTherapy	_____ Yes	_____ No	End date: _____
Phone	_____ Yes	_____ No	End date: _____

Step 7: For couples only: ask, **"Does my insurance policy cover "Family Counseling"?**

_____ Yes Family Counseling is covered ___ No Family Counseling is not covered

Please present this competed form at or before your first appointment.

PLEASE FORWARD A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

Thank you.
Bill

Relationship ReDiscovery Center: Disclosure Statement Page 1

The purpose of this document is to provide you with important information about your rights, my professional qualifications, administrative policies and a brief description of the counseling process.

Professional qualifications: Diverse educational, employment and life experiences have prepared me to offer counseling services to couples and individuals; addressing relationship issues, life transitions, infidelities, grief and loss, trauma, self esteem, depression, anxiety, ADHD, and other life challenges .

BS in Education from the University of Maine at Farmington in 1979
MS in Counseling from the University of Southern Maine in May of 2000
NCC, National Certified Counselor, Certificate # 62890, June 2000, expires May 31, 2021
LCPC, Licensed Clinical Professional Counselor, Maine, license # CC2120, June 2000, expires June 30, 2020
LMHC, Licensed Mental Health Counselor, Florida, license #MH12390, March 2014, expires March 31, 2021
American Mental Health Counselor Association, member since August 2005

Your Rights: If at any time you have questions, concerns or dissatisfactions please bring the matter to my attention so that we can jointly address the situation.

Concerns and complaints unresolved to your satisfaction may be filed at:
-Maine Board of Counseling Professionals Licensure, 35 State House Station, Augusta, Maine 04333; (207) 624-8626
http://www.maine.gov/pfr/professionallicensing/professions/counselors/index.html
-Florida Department of Health, 4052 Bald Cypress Way, Bin C, Tallahassee, FL 32399-3260, (850)245-4339
http://floridasmentalhealthprofessions.gov

-All counseling services are provided in a professional manner consistent with acceptable professional practices as outlined in the ethical standards of state regulations as well as the National Board of Certified Counselors, http://www.nbcc.org, the American Mental Health Counselors Association, http://www.amhca.org and The Gottman Institute, http:/www.gottman.com.

-The Federal Health Information Protection Act (HIPA) also outlines your rights in detail, which is available upon request and at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/

Service Limitations: This clinician's availability is extremely limited outside of session times. Therefore, I am not able to properly treat acute mental health needs include psychosis, hallucinations, active suicidal ideation or needs which require supports beyond weekly sessions. In such cases referrals to more appropriate service will be provided. - The services provided by this office do not include assessments or data collection for forensic purposes; include disability determination, parental assessments, DEEP, anger management or similar kind of needs. Referrals to more appropriately trained providers will be offered.

Confidentiality: All information will be held in strict confidence, except in the following circumstances:
- I must take action if there is a threat of serious harm to yourself or others.
- I must take action if there is reasonable suspicion of abuse to a child, elder or any incapacitated person.
- Information will be released when court ordered by a judge.
- Information will be released to others with your written permission.
- When services are provided to couples, written consent from both is required prior to the information release.
- Your confidential information may be utilized in my defense, should you take legal action against me or file a formal complaint with any regulatory board.
- I may anonymously discuss your case with my clinical supervisors. These colleagues are also bound to the ethical confidentiality rules of the profession.
- When using your medical insurance, information will be released for billing and any audit process as initiated by your insurance provider.
- If we run into each other in public, I will not acknowledge you, out of respect, unless you initiate a greeting.

_____	_____	_____	_____
Client	Date	Client	Date

The Counseling Process: In our first few sessions we will explore these policies, why you are seeking support, any related history and how you have tried to address the issues. Counseling sessions typically are weekly or every other week and can range from 45 minutes to an hour depending upon insurance eligibilities and your desires. Sessions may include discussion, processing, exploration, and optional homework. Referrals to other possible valuable community resources may be offered as appropriate. Periodically, we will check our progress by revisiting your treatment needs and goals. You always have the right to revise your goals or to end counseling at any time. Once the treatment goals have been met, an additional session is recommended to review and evaluate your counseling experience.

There are risk: When entering into a commitment of exploration and grow through counseling, very often one will feel worse before getting better. Successes in counseling often include going into difficult life challenges that may have been avoided or hidden because of the related discomforts. Counseling includes exploring these discomforts and finding healthy ways to go forward onto a more pleasurable life experience. Counseling services may also impact ones view of relationships in their lives. Goals typically include finding ways to gain increased trust and support from family and friends. However, in some cases, counseling can result in distancing within certain relationships and in some cases seperation and or divorce. There are no guarantees for desired outcomes.

Gottman Institute Disclaimer: While I have been trained in the Gottman Method of Couples Therapy, I want you to know that I and The Relationship ReDiscovery Center LLC are completely independent in providing you with clinical services and I alone am fully responsible for these services. The Gottman Institute or its agents have no responsibility for the services you receive here.

Rates: Intake Session: $150 / hr. All following sessions: $100/hr /individual: $125 /hr/couple. Returned check fee: $15.
Payments / Billing: Most insurances are accepted. It is the your responsibility to contact your insurance company before the first session to verify coverage. The client is responsible to pay all fees not covered by their insurance. (See Insurance Guidance at https://relationshiprediscoverycenter.com/forms) Co payments are collected the day of service. Unpaid balances will be billed monthly. Fee reductions maybe possible upon request.

Cancellations: 48 hours of advanced notice is expected, exceptions include emergencies and extenuating circumstances, Otherwise, a $35 fee will be changed. If a session is missed and you do not call, all previously scheduled future appointments will be removed and made available to others. **It is your responsibility to initiate the rescheduling of cancelled and missed sessions.**

Over Due Balances: Balances over 60 days due will be subject to a 1.5% service fee per month. If collection services become necessary, you will be held liable for all cost incurred, including collection agency fees, attorney fees, and court costs.

Mental Health Emergency Services: If you are in a need of immediate support call the Crisis Support numbers: Toll free anywhere in Maine 1-888-568-1112; go to your nearest emergency room or contact your Primary Care Provider.

Your signature(s) indicates that you have received, reviewed and agreed to this Disclosure Statement and you give consent for these services. If you are attending as a couple you also give consent for both to be involved conjointly. You have the right to withdraw this consent at anytime.

_____	_____	_____	_____
Client	Date	Client	Date

Relationship ReDiscovery Center
Video and PhoneTherapy: Policies, Procedures and Disclosures

- When using medical insurance for these services, I understand that it is my responsibility to contact my insurance company before the first session to verify coverage for video and phone sessions . (See Insurance Guidance at https://relationshiprediscoverycenter.com/forms) I understand that I am responsible to pay the fees not covered by my insurance.

-I understand that Bill Gould has contracted with *Jituzu*, which provides secure, HIPA compliant software for email and video communications. These services are accessible on a smart phone or tablet using the *Jituzu* App; and through the *Jituzu* website on laptops and desktops. Documents can be securely exchanged as email attachments on the *Jituzu* website only on a laptop or desktop. If I do not have access to a laptop, desktop or scanner, I will use mail to send and return documents using the address; Relationship ReDiscovery Center, 444 Main St, Lewiston, Maine 04240. Guidance is available by calling Bill at 207-689-5412.

-I understand that it is my responsibility to supply my own needed technology; cell phones, tablets, laptops, and or desktops computer. I understand that I am responsible for the security of all my electronic devises and related data, including any digital copies of any documents stored on my electronic devises.

-I understand I am responsible for my cell phone data charges that may occur when using a limited data plan. These charges can be avoided by using a secure wifi connection. When using Wifi, I understand that it is my responsibly to use only secure password protected wifi connections and not use unprotected public wifi.

-I understand there are rick associated with video and phone therapy, including, but not limited to, disruption of transmission by technology failures, interruptions and /or breaches of confidentiality by unauthorized persons.

-I understand that there will be no uninformed recording of any session by either party. I understand that Gottman Therapy sessions may be recorded for Bill Gould's Gottman Certification application process as allowed by my signed consent. I understand that I can retract my consent at any time.

-I understand that all policies as outlined in the *Disclosure Statement* also apply to Video and phone sessions.

-I agree to participate in video sessions dressed as if I were in public.

-I agree to not conduct phone or video sessions while driving.

-Video or phone sessions may not be appropriate in situations of high need; In such cases, referrals to more appropriate services will be offered.

-I understand that in case of an emergency my therapist will need to know my present location. At the start of each session I agree to inform my therapist of my current location. I understand that if I present with a life threatening emergency , serious suicidal or homicidial thoughts, psychosis or other high risk safety concern, my counselor may request assistance from my emergency contacts and or local authorities.

Emergency Contacts: (Please do not list your partner if you are receiving couple services)

Name: _____ Address:_____ Phone: _____ Relation: _____

Name: _____ Address:_____ Phone: _____ Relation: _____

My signature below indicates that I have read and understand the following andI give my informed consent to participate in TeleTherapy.

_____ _____ _____ _____
Client Date Client Date

Relationship ReDiscovery Center LLC
Client Intake Data Sheet

PLEASE HAVE YOUR INSURANCE CARD READY TO BE COPIED. PLEASE PRINT CLEARLY. THANK YOU.

Today's Date:		**Date of Birth:**
Client's First Name:	Middle	Last Name:
_____ Female _____ Male	__Single __Married __ Partnered __Separated __Divorced __Engaged	
Hm Phone (inc area code): Ok to leave detailed message __yes __no	Cell Phone (inc area code): Ok to leave detailed message __yes __no Schedule change; text ok? __yes ___no	Wk Phone (inc area code): Ok to leave detailed message __yes __no
Street / P.O. Address:		
City:		State / Zip:
Email Address:		
Have you called your insurance company for preauthorization: yes no		__Employed __Student __Disabled __Unemployed

Primary Care Provider	Date of last Physical:
Provider Name:	Provider Address:
Provider Phone :	Provider City / State/zip:
Psychiatric Med Manager	Date last seen:
Provider Name: Dr	Provider Address:
Provider Phone:	Provider City / State/zip:

Current medical Issues / illness:

Current Medication	Purpose	Dosage	Prescribed by:

Allergies:

List any know medical emergency which could occur during a session:

Emergency Contact

Name:	Address	Phone	Relationship to client:

Who referred you? How did you hear about the services here?

Please have your insurance card ready to be copied.

Relationship ReDiscovery Center LLC
Client Intake Data Sheet

PLEASE HAVE YOUR INSURANCE CARD READY TO BE COPIED. PLEASE PRINT CLEARLY. THANK YOU.

Today's Date:		**Date of Birth:**
Client's First Name:	Middle	Last Name:
_____ Female _____ Male	__Single __Married __ Partnered __Separated __Divorced __Engaged	
Hm Phone (inc area code): Ok to leave detailed message __yes __no	Cell Phone (inc area code): Ok to leave detailed message __yes __no Schedule change; text ok? __yes ___no	Wk Phone (inc area code): Ok to leave detailed message __yes __no
Street / P.O. Address:		
City:		State / Zip:
Email Address:		
Have you called your insurance company for preauthorization: yes no		__Employed __Student __Disabled __Unemployed

Primary Care Provider	Date of last Physical:
Provider Name:	Provider Address:
Provider Phone :	Provider City / State/zip:
Psychiatric Med Manager	Date last seen:
Provider Name: Dr	Provider Address:
Provider Phone:	Provider City / State/zip:

Current medical Issues / illness:

Current Medication	Purpose	Dosage	Prescribed by:

Allergies:

List any know medical emergency which could occur during a session:

Emergency Contact

Name:	Address	Phone	Relationship to client:

Who referred you? How did you hear about the services here?

Please have your insurance card ready to be copied.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).		TOTAL:		

10. If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

A26633 10-04-2005

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).		TOTAL:		

10. If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

A26633 10-04-2005

NAME _____ DATE _____

GAD-7 anxiety scale

Over the last 2 weeks, how often have you been bothered by the following problems?				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total score* _____ =	Add Columns	_____ +	_____ +	_____
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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NAME _____ DATE _____

GAD-7 anxiety scale

Over the last 2 weeks, how often have you been bothered by the following problems?				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total score* _____ =	Add Columns	_____ +	_____ +	_____
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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