affective
counseling

Name_____ **Date**_____

Name of guardian (if client is under 18)_____

Address_____

_____

Phone_____ **Email**_____

Insurance Carrier_____ **Member ID**_____

Group ID_____ **Client date of birth**_____

Policy holder name and date of birth_____

Emergency contact_____

Reason for visit_____

How did you find us?_____

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. A fee of $100 will be assigned for missed appointments or for cancellations by the patient when notice of the cancellation is given to the therapist less than 24 hours from the scheduled hour of the appointment.

Assignment of Benefits

I hereby authorize and direct my insurance carrier, _____, to issue payment check(s) directly to Affective Counseling for behavioral health services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that services rendered outside of scheduled psychotherapy sessions (i.e., writing reports, phone consultations, etc.) that exceed 15 minutes will be charged at $40 per each 15 minutes and is not reimbursable by insurance.

Authorization to Release Information

I hereby authorize Affective Counseling to: (1) release any information necessary to insurance carriers related to treatment; (2) process insurance claims generated during the course of treatment; and (3) use a photocopy of my signature to process insurance claims. This authorization will remain in effect until revoked by me in writing.

I have requested Affective Counseling to provide behavioral health services for myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred during the course of the treatment.

I further understand that fees incurred for services provided are due and payable on the date that services are rendered, and I agree to pay all such fees following each session or service.

Print Name of Patient/Responsible Party: _____

Patient/Responsible Party Signature: _____

Parent/Guardian Signature Relationship: _____

Date: _____

HIPPA Compliance

Affective Counseling HIPAA Notice of Privacy Practices

I. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is federal legislation that provides data privacy and security provisions for safeguarding your medical information. THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU:

A. MAY BE USED AND DISCLOSED, AND

B. HOW YOU CAN GET ACCESS TO THIS INFORMATION SHOULD YOU SO DESIRE.

II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR "PROTECTED HEALTH INFORMATION" ("PHI").

A. By law we are required to ensure that your PHI is kept private.

B. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health (including mental health) or condition, the providing of health care (including counseling) services to you, or the payment for such health care.

C. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI.

1. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice;

2. PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

III. HOW WE WILL USE AND DISCLOSE YOUR PHI.

Some of the uses or disclosures will require your prior written authorization; others will not. The different categories of our uses and disclosures are:

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations that Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:

1. For treatment. We can use your PHI within our practice (Affective Counseling) to provide you with mental health treatment, including discussing or sharing your PHI with Affective Counseling therapists, staff and supervisors, trainees and interns.

2. To obtain payment for treatment. We may use and disclose your PHI (to your insurance carrier) to bill and collect payment for the treatment and services we provided you.

B. Certain Other Uses and Disclosures that Do Not Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.

2. If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

3. If disclosure is mandated by Illinois DCFS. For example, if we have a reasonable suspicion of child abuse or neglect.

4. If disclosure is mandated by the Illinois Elder/Dependent Adult Abuse Reporting Law. For example, if we have a reasonable suspicion of elder abuse or dependent adult abuse.

5. To avoid harm. We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. When disclosure is required by federal, state, or local law.

C. Uses and Disclosures of your PHI that Require Your Prior Written Authorization.

In any situation not described in Sections III.A and III.B above, we will request and must obtain your written authorization before using or disclosing any of your PHI.

You may revoke your authorization to disclose your PHI in writing at any time.

IV. YOUR RIGHTS REGARDING YOUR PHI

Your rights with respect to your PHI are:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

B. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information.

C. The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented.

D. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession or to get copies of it; you must, however, make your request in writing. If you ask for copies of your PHI, we will charge you not more than $.50 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost of the summary, in advance.

V. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on March 1, 2018.

Printed Name of Client: _____

Client Signature: _____

Parent/Guardian Signature: _____

Date: _____

Coordination of Care

Coordinating with additional healthcare providers (i.e., primary care physicians, psychiatrists, school social workers, etc.) involved in your treatment can benefit the overall treatment outcome. If you would like your counselor to be able to communicate with additional health care providers, please complete the following.

____ I **do not** give permission to communicate with other healthcare providers

____ I **do** give permission to contact the following health care providers

1. Name_____

Address _____

Phone _____

2. Name_____

Address _____

Phone _____

3. Name_____

Address _____

Phone _____

_____ _____

Signature Date

Credit Card Authorization

I, _____, authorize Affective Counseling to charge my credit card for professional services as follows:

Please Initial:

_____ Reoccurring charges for co-pays or deductibles

_____ I understand that my credit card will be charged a fee of $100 for cancellations with less than 24 hours notice or for missed sessions

_____ I understand that this authorization is valid for one year unless I cancel the authorization in writing.

Please select your card type:

_____ Mastercard _____ Visa _____ Discover

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Security Code: _____

Billing Address: _____

_____

Signature: _____

Printed Name:_____

Date: _____

affective
counseling

I hereby consent to engaging in teletherapy with my existing therapist at Affective Counseling. I understand that “teletherapy” includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually, to Affective Counseling teletherapy service, Ring Central Meeting powered via Zoom or Doxyme (a HIPAA compliant video platform service).

I understand that I have the following rights with respect to teletherapy:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of psychotherapy, and

that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Illinois law.

(6) I understand that, per the ethical guidelines of the state of Illinois, teletherapy services can ONLY be provided to those residing in the state of Illinois at the time of service.

(7) I also understand that teletherapy is not always a covered service by my insurance plan, and it is my responsibility to check with my individual plan to determine if teletherapy is authorized. The patient will ultimately be responsible for all fees related to teletherapy that insurance does not cover.

(8) Teletherapy will be billed at the same rate of individual therapy services.

(9) Teletherapy is a temporary service that is being offered to all Affective Counseling clients due to extreme circumstances as a precautionary measure. Once these circumstances abate, therapy sessions

will return to in-person services as previously scheduled. Please contact your therapist directly if you have any questions.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Client Parent/Guardian Date

_____

Printed Name of Client Parent/Guardian

Signature of Therapist Date

_____ _____