Center of Hope Counseling

1001 Fairfield Drive
Mt. Pleasant MI 48858
Phone: (989) 954-HOPE(4673)

OFFICE USE ONLY
DX: _____
F: _____
T: _____
CPT Code: _____
Ins.- 3rd Party – Self-Pay
_____
Co-Pay: _____
Account No: _____ Date: _____

Clients Name:_____DOB:_____

Gender/Preferred Pronoun _____

Address:_____

Email address:_____ phone :_____

Insurance: _____ID#:_____ Name of insured: _____

Insured's DOB:_____ Address of the insured: _____

School: _____ Grade: _____

How did you hear about Center of Hope Counseling? Friend____ Phone Book_____ Other____

If Other, Describe (Health Professional, etc.): _____

If Minor Please fill out parent info

Father:_____ DOB:_____

Address(If different than client): _____

Employment: _____ Contact info (phone & email)_____

Mother:_____DOB:_____

Address(If different than client): _____

Employment: _____Contact info (phone & email)_____

Current Medications:_____
Describe Problems and or concerns: _____
Duration of Problems and or Concerns: _____
Describe Changes You Would Like to result from this counseling experience:
_____

How would you prefer to receive your statements?
(Please circle only one)

Text E-Mail Snail Mail

Where would you like your statement sent? (E-Mail Address, Phone #, House Address) _____

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Fee Agreement

Client Name: _____ Date: _____

A counseling session usually lasts 60 minutes. Our fee per session is **$130.00.** If your insurance company does not cover our services, your fee will be based on you family income using our sliding scale as follows:
(Please provide the counselor with your insurance card for billing purposes)

Annual Gross Family Income:	Fee:
$40,000 or less	$65
$41,000 to $60,000	$75
$61,000 to $80,000	$85
$81,000 or above	$95

Other Services

Dietetic Services	
Initial Session	$100
½ Hour sessions	$50
Session with intern	$25
Group Therapy fee	$30
Encountering Life Competently	$35
Late cancellation fee or no show fee	$35
Writing Letters for colleges or other purposes	$15
Phone calls up to 15-19 minutes	$20
Phone calls 20-29 minutes	$30

Phone calls over 30 minutes will be charges according to session fee.

***Bills that are accrued over $100.00 must be paid in full before another session is scheduled.**

INSURANCE AUTHORIZATION

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to: _____ all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Center of Hope Counseling to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. We are located 1001 Fairfield Drive, Mt. Pleasant, Michigan 48858. Our tax I.D. No. is: 38-3387304.

I understand that Center of Hope Counseling may be able to bill my insurance company. If not, I understand that it is my responsibility to pay each session at the time of service, and to contact my insurance company for reimbursement. I also understand that my fee will be $130.00 if covered by insurance or $_____(see chart above) if based on a sliding scale fee. I understand if I do not attend my scheduled appointment and have not given at least 24 hours in advance notice, I may be billed $35.00.

_____

Responsible Party Signature Relationship Date

_____

Client/guardian/print Counselor Date

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UPDATE: Out of Pocket Payment Policy

Dear Clients,

As of October 1, 2018 we will be employing a new system for out of pocket payments (ie. Copays, deductible payments, self pay). The new system we will be using is called Stripe. After each session, Stripe will automatically be running the card on file for the session out of pocket fees. The Stripe uses an Auto-Pay system between midnight and 2 am each night. Please be advised that a charge could occur the night after the session (for copays or self pay) or when insurance company deny due to unmet deductibles. Having awareness of your insurance policy and coverage will be very helpful in avoiding any confusion about charges.

This policy change is occurring to help avoid large charges to cards on file at the end of the month and also to ensure that all client's accounts remain active. If you have any question regarding the Strip please have your therapist contact administration/billing department on your behalf.

I understand by signing this policy change update that I am authorizing Center of Hope Counseling to utilize the undersigned debit/credit card to pay the balance on my account via Strip AutoPay.

Client Name: _____

Name on Debit/Credit Card: _____

Debit/Credit Card Type Visa MasterCard
Other_____

Card number_____

Expiration Date: _____ Security Code: _____

Billing Zip Code: _____Employer (for HSAs)_____

Card Holders Phone_____ Client Phone_____

Card Holders email_____Client email _____

Responsible Party Signature and date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCOLSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law under HIPPA including the HIPPA Privacy and Security Rules, and the *ACA Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain to privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.

Required by law: Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Following is a list of the categories of uses and disclosures permitted by HIPPA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings: We may have to disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate to the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPPA.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight: If required, we may disclose PHI to a health oversight agency for activates authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a crime on the premises.

Specialized Government Functions: We may review requests from U.S. Military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the

purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety: We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research: PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission: PHI may only be disclosed after a special approval process or with your authorization.

With Authorizations: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit them in writing to Lisa Carpenter, MA, LPC, at 113 W. Broadway St. Suite 115 Mount Pleasant, MI 48858.

- **Right of Access to Inspect and Copy:** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where this is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact Lisa Carpenter if you have any questions.
- **Right to Accounting of Disclosures:** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if your request more than one accounting in any 12-month period.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the use of disclosure of your PHI, for treatment, payment, or health care operations. We are not required to agree to your request unless the request if to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for restriction.

- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification**: If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice**: You have a right to the copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Lisa Carpenter, at 1001 Fairfield Drive, Mount Pleasant MI 48858 or with the Secretary of Health and Human Services at 200 Independence Ave. S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is March 2016

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Notice Of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Center of Hope Counseling Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Privacy Officer, Lisa Carpenter @ 1001 Fairfield Dr., Mount Pleasant, MI, 48858

Signature of Patient/Client **Date**

Signature of Parent, Guardian or Personal Representative* **Date**

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Patient/ Client Refuses to Acknowledge Receipt:

Signature of Staff Member **Date**