Resiliency Consultant & Therapeutic Services

Client Information Form

Client Name_____

Address _____City _____State _____Zip _____

E-mail_____

Age _____ Date of Birth _____

❏ Male ❏ Female ❏ Single ❏ Married ❏ Divorced ❏ Widowed

Where would you like me to leave you messages?

❏ Home ❏ Work ❏ Cell ❏ E-mail ❏ None

If there is an emergency at the office and we must cancel your appointment, where should we call? ❏ Home ❏ Work ❏ Cell ❏ E-mail ❏ None

Employer-Self_____Occupation_____

Employer-Spouse_____Occupation_____

Spouse's Name (if applicable): _____ ( )

Emergency Contact Name Phone Number Responsible Party Information

RCTS requires a responsible party in addition to the client, unless the insured party is the client.

Payment (Check One) □ Insured □ Self-Pay

Full Name _____Relationship _____

Mailing Address _____

City _____State ____Zip Code_____

Home Telephone # _____Work Telephone #_____

Social Security Number #_____Date of Birth _____

If you do not have insurance please skip to "Assignment and Release" Insurance Information

Primary Insurance Company Name: _____

Mailing Address: _____

Telephone Number: _____

ID/Policy Number ID/Policy Number _____

Group Number Group Number: _____

Secondary Insurance Company Name: _____ Mailing

Address _____ _____

Telephone Number_____ _____ ID/Policy

Number ID/Policy Number _____

Group Number Group Number: _____

Friends/Family Other Assignment and Release: I assign my insurance benefits to be paid directly to the provider. I am financially responsible for non-covered services. I also authorize the provider to release any information required to process this claim. We may send claims to your insurance company as a courtesy. You are responsible for any unpaid balance within 30 days of receiving our bill.

Patient Signature X_____

Date X_____ (Required for all patients OVER 13 years)

Responsible Party, Guardian, Parent Signature Date Financial Responsibility I understand the appointment time has been held especially for me. I also understand that missed appointments and cancelled appointments less than 48 hours in advance will be billed at 100% of the rate of the provider. Reminder calls will be made as a courtesy.

_____ (Initials)

Credit Card On File For your convenience, co payments and unpaid balances can be charged to your credit card on file. Receipt of payment will be mailed directly to you. I allow RCTS to use my credit card for this purpose.

_____ (Initials)

Credit Card Number_____

Expiration Date _____ CCV _____

Issued Under Name (the way it appears on the card) _____

Zip Code _____attached to card Address attached to card (If different from residence

Why are you seeking counseling?

_____

_____

_____

_____

Are you currently in counseling elsewhere? ❑ Yes ❑ No ***If yes, do not complete this form***

How were you referred to my office? If internet, please list the directory you used to locate my ad._____

AGREEMENT FOR THERAPY

I,_____

❑ Agree to receive therapeutic services provided by Felice Hightower Britt, MA, LPC.

❏ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.

❏ Furthermore, I understand that I am expected to be an active participant in this process.

❏ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

❏ My signature below means that I understand and agree with all of the points above.

_____

Client Signature Date

I have inquired to insure that the patient understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

HIPPA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including

demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

_____ _____

Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Felice Hightower Britt, MA, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Court fees/Treatment Record Fees

Felice Hightower Britt reserves the right to charge treatment records at $25 per record and if therapist is called to be a part of client court proceedings the fee is $25 per hour. If for some unfortunate reason client sees fit to take counselor to court, client will be responsible for all of counselor court and attorney/arbitration costs regardless of outcome.