Client Demographics

Date:_____

Name_____

Address_____

City, State, Zip Code_____

Phone (H)_____ (C)_____(W)_____

DOB_____ Age_____ SS#_____

Emergency Contact Name_____Phone_____

Primary Care Physician_____Phone_____

Is this client a Minor? Yes No

Legal Guardian_____Phone_____

ONLY COMPLETE IF INSURED THROUGH PARENT OR EMPLOYER

Name of Policy Holder _____ DOB of Policy Holder_____

Relationship to Client _____

Place of Employment _____ Phone Number_____

Name of Insurance Company _____

Member ID_____ Group Number_____

Copay Amount for Specialist_____ Annual Deductible_____

Comments: _____

FOR MEDICAID RECIPIENTS

Name of Insurance Company _____

Member ID Number _____

Medicaid ID Number (Can be found on the card with the horse logo) _____

Please complete and return this information.

You may fax forms, ID, and front/back copies of your insurance card to our office: 859.353.4200

1795 Alysheba Way Ste 1001 Lexington, KY 40509 I 2039 Regency Rd Ste 8 Lexington, KY 40503
Phone 859.687.0416 I Fax 859.353.4200 I email: Info@essentialhealingiop.com I Web: www.essentialhealingiop.com

INFORMED CONSENT

By reading and signing below, you acknowledge and agree to participate in mental health services provided by Essential Healing IOP, Inc "EHIOP", its employees, and independent contractors. We understand that beginning a therapeutic relationship in a counseling setting may be a new experience and that you may have many questions. We will do our best to answer any questions or concerns you may have during your initial visit. The information below explains processes and other information about EHIOP's policies and procedures, State and Federal Laws, and your rights regarding therapy. All EHIOP employees and contractors have met the highest level of education, certification, and licensing as required by Kentucky state law. Counseling practices, philosophy, risks regarding your therapeutic processes, and insurance and plan limitations will be discussed.

TREATMENT PROCESSES AND DOCUMENTATION It is the provider's responsibility to keep accurate chart records including assessments, case notes, treatment plans, and progress notes. By signing this agreement, you are consenting to the treatment plan that your provider creates and agree to any goals, objectives, and therapy techniques that may be used during your therapeutic processes.

CONFIDENTIALITY Confidential information whether discussed in session or with staff is not disclosed without your written permission with exception to the following:

1. Where you sign a release of information to have specific information shared;
2. Information you tell EHIOP about physical, sexual or elder abuse; then, by Kentucky State Law, I have to report this to the Kentucky Department of Children and Family Services;
3. If you tell EHIOP you are in danger of harming yourself or others;
4. Diagnosis and dates of service shared with your insurance company to process your claims;
5. Information shared with therapist's clinical supervisor, if applicable;
6. When disclosure is required by law.

INSURANCE BILLING If you plan to use insurance to pay for services, claims will be sent to your insurance company based on information used at the time of service. Occasionally, insurance information may change or may not be up to date. If for any reason, inaccurate information related to deductibles, co-pays, or number of available sessions, etc. is obtained at the time of service, EHIOP will bill you for any additional costs associated with mental health services rendered. Additional services may be denied until your account balance is brought current. If balances remain unpaid for more than 60 days, your information will be sent to a collection agency. Depending upon the services rendered and the providers who are assigned to your case, our partnering agency may bill your insurance for the services rendered.

SELF PAY I agree to allow EHIOP to keep a copy of my credit card on file and I agree to allow EHIOP to charge my account for any balances I incur.

MISSED APPOINTMENT FEES Appointments will be cancelled and $35.00 fee will be assessed for sessions which you are 15 minutes late without notice. If you cancel your appointment without 24 hour notice, EHIOP will charge you a fee of $25.00. It is essential to keep your appointments in respect for your provider's time.

RETURNED CHECK/NSF FEES If your check is returned for non-payment/insufficient funds, your account will be assessed a $40.00 fee.

TRAINING AND SUPERVISION EHIOP is also a training center for Masters and Doctoral level counseling and psychology interns and for paraprofessionals. All Interns are under the direct supervision of licensed mental health professionals. In order to ensure that counselors receive the best possible training, and that clients are well served, some sessions will be video or audio taped. Tapes are viewed by counselors and clinical supervisors only, and are erased in a timely manner. There will be advance notice of a taping and it will be with your full and complete awareness. You must agree to have your family/child's sessions taped in order to receive services within the agency. If your child is assigned an intern, the intern who is assigned to you is on a time-limited, contractual basis. Therefore, it is possible that the intern may leave prior to the end of your therapy. If this does occur, we will do everything possible to ensure a smooth transfer to another counselor.

CONTACTING US If you need to contact us between counseling sessions please call our office. E-mail, text messages and social networking sites are not always confidential and we may not be able to respond in a timely manner. By listing your email address on the signature page, you agree to communicate through our HIPAA compliant email with the domain @essentialhealingiop.com. If you experience a medical emergency, call 911. If you experience a non-medical emergency mental health related crisis, you can call our office and a provider may return your call. If no call is received within 10 to 15 minutes or you cannot wait, call 911.

EMAIL Address:_____

Questions:_____

_____

Concerns:_____

_____

Were your questions and concerns addressed? Yes No

_____

Client Signature Date

_____

Provider or Administrative Staff Signature Date

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CLIENT RIGHTS

Right to request how we contact you. It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records. You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records. You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records. If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures. You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain. If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

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.

Essential Healing IOP, Inc "EHIOP" has been and will always be totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes our policies related to the use and disclosure of your healthcare information. Your health information may be used for the purposes of providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Kentucky State Law, we are obligated to report this to the Department of Children and Family Services; If you provide information that informs us that you are in danger of harming yourself or others, we must report this also; Information may be used to remind you of /or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order; Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of pocket and in full.

METHOD OF CONTACT BY OFFICE We may send you appointment reminders by text message or phone call and leave a voice message. To authorize email, please list it below.

Email:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I have read and received a copy of the Notice of Privacy Practices and Client Rights document.

_____

Signature (Parent/Guardian must sign if client is a minor) Date

_____

Provider or Administrative Staff Signature Date

HIPAA Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

I authorize Essential Healing IOP, Inc "EHIOP" to gather information from, collaborate with, use, and disclose the protected health information described below with:

- ☐ Primary Care Physician_____
- ☐ Emergency Contact_____
- ☐ Partner Agencies- KOI and Creative Solutions
- ☐ Representatives of child's school_____
- ☐ Other_____

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____. **OR**

b. □ all past, present, and future periods.

EXTENT OF AUTHORIZATION

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR

b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug tx
□ Other (please specify): _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Essential Healing IOP, Inc "EHIOP". I understand that a revocation is not valid to the extent that Essential Healing IOP, Inc "EHIOP" has acted in reliance on such authorization. This authorization does not expire until I submit a written request. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING PROVIDER OR ORGANIZATION: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for disclosure of this information by the recipient and, if that occurs, federal law may not protect the information.

_____

Client Signature (Parent/Guardian must sign if client is a minor) Date

_____

Provider's Signature Credentials Date

PCP Consent for Communication

Date: _____

Name_____

DOB_____ Age_____ SS#_____

Primary Care Provider_____

Agency or Office Name_____

Phone _____(F) _____

Email_____

PURPOSE OF COMMUNICATION

This letter is to inform my primary care physician that I am receiving services at Essential Healing IOP, Inc (EHIOP) for mental health services.

- ☐ I plan to receive the following treatments while in the care of Essential Healing IOP, Inc (EHIOP):
  - Mental Health Counseling
  - Medication to reduce mental health symptoms
  - Both
- ☐ My mental health provider would like to make recommendations for treatment based on the following symptoms:

  _____

  _____

  _____

  - Dx 1:_____
  - Dx 2:_____
  - Dx 3:_____

I give Essential Healing IOP, Inc "EHIOP" and my PCP office, listed above, permission to share my private health information with each other. This consent does not expire until I submit written request to terminate communication.

_____

Client Signature Date

_____

Provider or Administrative Staff Signature Date