New Client Data

The SUMMIT Therapy Center of Wooster, LLC
4419 Cleveland Rd., Wooster, OH 44691
Ph: (330) 345-8450 FAX: (330) 345-5899

Please print clearly and fill all sections out COMPLETELY. Thank you! Date: _____

Patient

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Sex (M or F): _____

Phone: _____ Yours or Parent's? (circle) Email: _____

Birth Date: _____ SSN: _____

Employer _____ Address: _____

Occupation: _____ Education Completed: _____

Family Physician: _____ Where: _____

Have you ever seen a mental health professional before? _____ When? _____
Please list current allergies, medication/dosages, and conditions being treated:

_____

Primary Insurance? (Y or N): _____ **Secondary Insurance? (Y or N):** _____

Who is the Subscriber of Insurance? _____

Subscriber Address: _____

Subscriber's Birth Date: _____ **Subscriber's SSN:** _____

Insurance Company: _____ ID: _____ Group: _____

NO SHOW POLICY: You will be charged $50.00 for any missed appointments that are not cancelled 12 hours prior to your appointment. Insurance does not provide coverage for missed appointments.

Responsible Party (if not the client or insurance subscriber):

Name: _____ Address: _____

Phone: _____ Relationship to Client: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you to us? _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment of any professional services rendered. I hereby authorize The SUMMIT Therapy Center to disclose any protected health information of named individuals listed above to receive payment of medical benefits for service rendered by The SUMMIT Therapy Center staff. I certify that the above information is true and correct to the best of my knowledge. I will notify The SUMMIT Therapy Center of any changes to the above information.

Client/Guardian: _____ Therapist _____ Date: _____

PATIENT FINANCIAL POLICY

The Summit Therapy Center of Wooster, LLC 4419 Cleveland Rd. Wooster, Ohio 44691

Patient's Name_____ Date of Birth_____

Responsible party (if other than patient, patient is under 18 years of age) _____

Patient (or responsible party) agrees to pay for all portions of services determined by your insurance company (co-payments, deductibles, and non-covered charges). Co-payments or any uninsured charges are due in full at the time services are provided by our office.

Commercial Insurance Carriers: **You are required to present a valid insurance card upon your initial evaluation and as needed throughout your care.** We will bill most insurance carriers for you if proper paperwork is provided to us. Once verification of benefits is obtained, any outstanding balances, **co-payments, and deductibles are due at the time of your appointment.** Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. We do not participate in cases for Worker's Compensation.

Professional Fees: **For those billing their insurance, the initial evaluation will be billed at $140.00 with subsequent visits billed at $130.00. For people without insurance and choosing to Self-Pay, the fee is $100 per hour.** Other professional services (i.e., legal reports, court appearances, treatment summaries, professional consultations, and telephone conversations) are also billed at the same hourly fee but are not billable services to insurance companies. All prior balances must be paid in full before requesting any of these additional services.

No-Show Policy: You will be charged $50.00 for any missed appointments that are not cancelled 12 hours prior to your appointment. Insurance does not provide coverage for missed appointments.

Methods of payment: **Cash, personal checks, credit and debit cards are accepted except American Express cards.** All **co-payments and deductibles are due at the time of your appointment.** You may also receive a statement of your account indicating a balance due, after insurance has processed claims. **This requested payment is due upon receipt.** In circumstances of unusual financial hardship, we are willing to set up a payment plan in which you will be required to sign the Patient Promissory Financial Agreement.

Bad Debts: Returned checks are assessed a $30 NSF charge and will be report to the local district attorney's office if not paid within 10 days of being returned to our office. Finance charges will be assessed on any account in violation of the designated payment agreement. If accounts past 120 days are not paid according to the terms, the patient understands that The Summit Therapy Center will use legal means to secure payment by filing with an outside collection agency or small claims court. In the event that your account is turned over for collections, you or the patient agrees to pay all fees assessed in the collection of that debt. We reserve the right to disclose all billing and account balance data necessary for collection of past due services.

I have read, understand and agree to the above Patient Financial Policy for payments of professional fees

Signature_____ Date_____ Rev.: 4-1-2019

Psychotherapist and Patient Services Agreement

The SUMMIT Therapy Center of Wooster, LLC 4419 Cleveland Road, Wooster OH 44691 (330) 345-8450

Welcome to The SUMMIT Therapy Center of Wooster, LLC. This document (the Agreement) contains important information about our services and business policies. It also contains summary information about the **Health Insurance Portability and Accounting Act (HIPAA).** HIPAA requires that we offer you a Notice of Private Practices (the Notice) for use and disclosure of personal health information for treatment, payment, and health care operations. The Notice explains HIPPA and its application to you acknowledging that we have provided you with this information at the end of your first session. We can discuss any questions you may have about the information at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action, such as if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

Psychological Services:

Psychotherapy varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for the therapy to be most successful, you may have to work on things we talk about both during your sessions and at home.

Since therapy often involves discussing aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and helplessness. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. If you have any questions, please discuss them with your therapist as they arise.

Meetings:

Your therapist typically conducts an evaluation that lasts 1 to 2 sessions. A 50-minute session is usually scheduled at an agreed upon time. Once an appointment is scheduled, you will be expected to pay for it unless you provide **12 hours advance notice of cancellation. A $50 No-Show fee** will be charged if no cancellation is made within 12 hours of your appointment. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. It is your responsibility to call and reschedule your missed appointment.

Contacting Your Therapist:

Due to fluctuating work schedules, your therapist may not be immediately available by telephone. You do have the option of leaving a message for your therapist via voicemail, which is available 24 hours a day. Your therapist will make every effort to return your call on the same day. With the exception of weekends and holidays. If you are in an emergency situation, you may contact 911, the county crisis service (330) 264-9029, or the nearest emergency room for immediate assistance.

Psychotherapist and Patient Services Agreement

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Limits on Confidentiality:

The law protects file privacy of any communications between a patient and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require you to provide written, advanced consent. Your signature on this Agreement provides consent for the activities below:

- Your psychotherapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, they will make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. Your therapist will note all consultations in your Clinical Record.
- The SUMMIT Therapy Center of Wooster, LLC, employs Office Staff. In most cases, your therapist needs to share protected information with the Office Staff for administrative purposes, such as scheduling and billing.
- Information is shared with other SUMMIT Therapy Center psychotherapists as needed to provide "on call" coverage when your therapist is away.

All mental health professionals are bound by the same rules of confidentiality. All of our staff members have received ethical training about protecting your privacy and have agreed not to release any information outside of The Summit Therapy Center office.

There are some situations where we are permitted or required to disclose information without either your consent or authorization:

- If a government agency is requesting the information for health oversight activities, your therapist may be required to provide it for them.
- If a patient files a complaint or lawsuit against a therapist, they may disclose relevant information regarding that patient in order to defend themselves.
- The SUMMIT Therapy Center therapists are mandated reporters. This means that the psychotherapist must report any abuse or neglect towards a child to Wayne County Children's Services.
- Any threats of harm to others, or self-harm, must be reported to the appropriate service by your psychotherapist.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

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Professional Records:

Pursuant to HIPAA, your therapist will keep Protected Health Information about you in a professional record file that constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, goals that are set for treatment, and your progress towards those goals. It may also include your medical and social history, your treatment history, past treatment history that we may receive from other providers, reports of history, your treatment history, past treatment history that we may receive from other providers, reports of any professional consultations, and any reports sent – including clinical reports to your insurance carrier.

Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. The request must be signed by you and dated not more than 60 days from the date it is submitted in writing. We recommend that you initially review your record in the presence of your therapist or have them forward it to another mental health professional so you can discuss the contents with that professional. A copying fee of 50 cents per page will be assessed to you, plus postage if mailing is required.

Patient Rights:

An Ohio Notice Form is posted in the lobby of SUMMIT Therapy Center for your review, and a copy of the form can be made available to you upon request. Please refer to the Ohio Notice Form that describes policies and practices to protect the privacy of your health information.

Supervision:

Supervision and consultations are provided by Leslie Feder, LISW-S and Douglas Princehorn, LISW-S. You may receive insurance statements with Leslie's or Doug's name on it. All information regarding your counseling services will be maintained within the strictest legal limits of confidentiality.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE HIPAA NOTICE FORM DESCRIBED ABOVE HAS BEEN MADE AVAILABLE TO YOU.

_____ _____

Patient Date

_____ _____

Therapist Date

Rev. 4/1/19

Confidentiality Addendum for Minors and Parents

The SUMMIT Therapy Center of Wooster, LLC 4419 Cleveland Road, Wooster OH 44691 (330) 345-8450

Parents of children who are under 14 years of age, and not emancipated, have the right to examine their child's treatment records unless the psychotherapist decides that such access would injure the child. Children between 14 and 18 years of age may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period). No information about those sessions can be disclosed to anyone without the child's agreement.

For children 14 and over, it is our policy to request an agreement between the patient and his/her parents, allowing the therapist to share general information about the progress of their child's treatment and his/her attendance at scheduled sessions. The therapist may also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless the therapist feels that the child is in danger or is a danger to someone else. In this case, they will notify the parents of any concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and do what is best to handle any objections that might occur.

_____ _____

Parent signature Date