R. E. A. L. Counseling, LLC

The Past is Determined  The Future is Your Decision

Initial Information

Today's date: _____

A. Identification
Client name: _____ Date of birth:_____Age: _____
Nicknames or aliases:_____SS #: _____
Home street address:_____Apt.: _____
City:_____State:_____Zip: _____
Home/evening phone:_____E-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions:

_____

Please be advised that all correspondence via text/email is not protected by HIPPA
As a courtesy, we have the ability to send out reminders for your upcoming appointments. Please complete the information below if you would like to be reminded of your schedule appointment.
Text Number:_____Service carrier:_____(Verizon, AT&T…)
Email:_____Notified_____day(s) prior to appointment

B. Referral:
How did you hear about us? _____
Medical: Clinic/doctor's name: _____
Phone:_____Fax: (if known) _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?
❑ Yes ❑ No

C. Work/School Information:
Employer/School: _____
How many years employeed?_____What grade level?_____

D. Emergency Information:
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name:_____Phone:_____Relationship: _____
Address:_____
Significant other/nearest friend or relative not residing with you: _____
Contact info:_____Any other identifying info: _____

E. Therapy:
Please describe the main difficulty that has brought you to see me:

_____

_____

_____

FINANCIAL INFORMATION FORM

Patient's name:_____ Birth Date: ____/____/____

Address: _____ Home Phone:_____

Employer/School:_____Email: _____

Financially responsible: _____ Relationship to client _____

Employer/Occupation:_____ Email: _____

Contact info is same as client ____Yes ____No If no, please complete additional contact info:

Address:_____ Phone:_____

Health Insurance Carrier/Company

Name of company:_____

Name of policyholder (if not the patient):_____ Birth Date: ____/____/____

Policy #:_____ Phone:_____

Limits to mental health benefits:_____

My copay/coinsurance is $: _____ per session

Name of Secondary Insurance Company ☐ ***I do not have Secondary Insurance***

Name of company:_____

Name of policyholder (if not the patient):_____ Birth Date: ____/____/____

Policy #:_____ Phone:_____

Limits to mental health benefits:_____

My copay/coinsurance is $: _____ per session

What You Should Know about Managed Care and Your Treatment

Your health insurance may pay part of the costs of your treatment, but the benefits cannot be paid until a managed care organization (MCO) authorizes this (says they can be paid). The MCO has been selected by your employer, not by you or me. The MCO sets some limits on us, and you need to know what these are before we go further.

Confidentiality

If you use your health insurance to help pay for psychotherapy, you must allow me to tell the MCO about your problem and give it a psychiatric diagnosis. You must also permit me to tell the MCO about the treatmen I am recommending, about your progress during treatment, and about how you are doing in many areas of your life (functions at work, in your family, and in activities of daily living). I am not paid separately for collecting, organizing, or submitting this information, and I cannot bill you for these services. All of this

information will become part of the MCO's records, and some of it will be included in your permanent medical record at the Medical Information Bureau, a national data bank that is not open to the public including you. The information will be examined when you apply for life or health insurance, and it may be considered when you apply for employment, credit or loans, a security clearance, or other things in the future. You will have to indicate that you were treated for a psychological condition and release this information, or you may not get the insurance, job, loan, or clearance.

All insurance carriers claim to keep the information they receive confidential, and there are federal laws about its release. The laws and ethics that apply to me are much stricter than the rules that apply at present to MCOs. *There have been reports in the media about many significant and damaging breaches of confidentiality by MCOs*. If you are concerned about who might see your records now or in the future, we should discuss this issue more fully before we start treatment and before I send the MCO any information. You should evaluate your situation carefully in regard to confidentiality. For some people and some problems, the privacy of their communications to their therapist is absolutely essential to their work on their difficulties. For others, their problems are not ones that raise much concern over confidentiality.

Treatment

The MCO will review the information I send it and then decide how much treatment I can provide to you. *The MCO can refuse to pay for any of your treatment, or for any treatment by me. Or it may pay only a very small part of the treatment's cost, and it can prevent me from charging you directly for further treatment we agree to*. Finally, it can set limits on the kinds of treatments I can provide to you. These limited treatments may not be the most appropriate for you or in your long-term best interest. The MCO will approve treatment aimed at improving the specific symptoms (behaviors, feelings) that brought you into therapy, but it may not approve any further treatment. The MCO will almost always require you to see a psychiatrist for medication evaluations (and prescriptions), *whether you or I think this is appropriate.*

When it does authorize our treatment, the MCO is likely to limit the number of times we can meet. Your insurance policy probably has a maximum number of appointments allowed for outpatient psychotherapy (usually per year, though there may be a lifetime limit as well), but the MCO does not have to let you use all of those. It may not agree to more sessions, even if I believe those are needed to fully relieve your problems, or if I believe that undertreating your problems may prolong your distress or lead to relapses (worsening or backsliding).

If the MCO denies payment before either of us is satisfied about our progress, we may also need to consider other treatment choices, and they may not be the ones we would prefer. We can appeal the MCO's decisions on payment and number of sessions, but we can only do so within the MCO itself. We cannot appeal to other professionals, to your employer, or through the courts. This state does not have laws regulating MCOs —that is, laws about the skills or qualifications of their staff members, about access to medical and psychological records by employers and others, or about the appeals process.

You should know that my contract or your employer's contract with a particular MCO prevent us from taking legal actions against the MCO if things go badly because of its decision. *My contract may prevent me from discussing with you treatment options for which the MCO will not pay.* I will discuss with you any efforts the MCO makes to get me to limit your care in any way.

The particular MCO in charge of your mental health benefits can change during the course of your treatment. If this happens, we may have to go through the whole treatment authorization process again. It is also possible that the benefits or coverage for your treatment may change during the course of our therapy, and so your part of costs for treatment may change.

Lastly, even if we send all the forms and information to the MCO on time, there may be long delays before any decisions are made. This creates stressful uncertainty and may alter our earlier assumptions about the costs and nature of your treatment.

Our Agreement

If, after reading this and discussing it with me, you are concerned with these issues, you may have the choice of paying me directly and not using your health insurance. This will create no record outside of my files.

I chose NOT to file my counseling services with my insurance plan and would like to discuss further payment options. Signature: _____

If you do not have insurance, how will you pay for services from this office? _____

I give this office permission to release any necessary information obtained during examinations or treatment of this patient to support any insurance claims on this account or to secure timely payments due to the assignee or myself.

I understand that I am responsible for all charges for services provided.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to R.E.A.L. COUNSELING, LLC

_____ _____ ____/____/____

Signature of client (or parent/guardian/policy holder) Printed name Date

R. E. A. L.  Counseling, LLC

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Professional Disclosure Statement," "Notice of Privacy Practices" and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 business day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

R. E. A. L. Counseling, LLC

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PERMISSION TO CONTACT

Name of Client: _____

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that R.E.A.L. Counseling, LLC has either offered me or provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: R.E.A.L. Counseling, LLC, PO Box 31447, Myrtle Beach, SC 29588/Phone: 843.273.0077/Fax: 843.273.0075/Email: info@realcounselingllc.com

I also understand that I am entitled to receive updates upon request if R.E.A.L. Counseling, LLC amends or changes the Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Patient, if signed by someone other than patient

It may occasionally be useful or necessary to send you information by mail, email and/or text. If you believe that this would compromise your privacy or safety, you have the right to deny permission and request an alternate form of communication, such as phone contact. If your circumstances change, you can revoke permission to receive mail at any time.

WE DO EVERYTHING POSSIBLE TO PROTECT YOUR INFORMATION, PLEASE UNDERSTAND THAT ALL ELECTRONIC CONTACT VIA EMAIL AND/OR TEXT CANNOT BE PROTECTED BY HIPPA

I give permission for **R.E.A.L. Counseling, LLC** to send written communication to me related to my services. This is not to include emergencies and/or direct therapeutic interactions. I understand that I may withdraw this permission at any time.

Preferred Mailing Address:

_____

I consent to contact via email and prefer this email to be used: _____

I consent to text messages and prefer this number to used: _____

Cell Phone Carrier: _____ (Verizon, Sprint, AT&T…)

_____ _____

Signature Printed Name:

THIS FORM WAS SIGNED ON _____ _____

(Date) (Client Initials)

R.E.A.L.  Counseling, LLC

Authorization to Release Medical Records

Patient's Name:	**DOB:**
Patient's Current Address:	
Patient's Previous Address:	
Patient's Current Phone #:	

INFORMATION TO BE RELEASED

☐ All Records

☐ Other, (specify): _____

REASON FOR REQUEST

☐ **Personal Records** ☐ **Specialist/Referral** ☐ **School** ☐ **Insurance** ☐ **Legal**

☐ **Transferring Out**

Transferring Reason: ☐ **Relocation** ☐ **Change Insurance** ☐ **Unhappy with Staff/Practice**

☐ **Other:**_____

DELIVERY OF RECORDS

☐ **Pick Up In Person** ☐ **Via Regular Mail** ☐ **Fax :(___)**_____

RELEASE INFORMATION TO

NAME:

ADDRESS:

CITY: **STATE:** **ZIP:**

*****By signing below, I understand that (1) I release REAL Counseling, LLC and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damage, which may result from the release of information authorized by this Consent for Release of Medical Information; (2) this consent is valid from the date signed and continues until I revoke this authorization by giving R.E.A.L Counseling, LLC written notice; (3) I may revoke this authorization at any time, unless the action has already been taken utilizing this signed consent or it the authorization was obtained as a condition of obtaining insurance coverage; (4) the practice will not condition treatment or payment based on my signing this authorization; (5) I am signing this authorization freely; (6) no one has pressured me to sigh this authorization; (7) I acknowledge that I've had an opportunity to review this authorization and understand the intent and use; (8) the information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.**

_____ _____ _____

CLIENT OR PARENT/LEGAL GUARDIAN SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**

ONLY COMPLETE PAYMENT INFORMATION IF INSTRUCTED BY THERAPIST.

PLEASE FILL OUT BELOW IF PAYING BY MASTERCARD, DISCOVER, AMEX, OR VISA

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

CARD NUMBER	**3 0R 4 DIGIT VERIFICATION NUMBER**
SIGNATURE	**EXPIRATION DATE**

R.E.A.L Counseling, LLC

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND/OR YOUR CHILD(REN) [AS A PATIENT OF THIS PRACTICE] MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR AND/OR YOUR CHILD(REN) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. Our Commitment to You and/or your [Child(ren)] Privacy

Our practice is dedicated to maintaining the privacy of you and/or your child(ren) individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and/or your child(ren) and the treatment and services we provide to you and/or your child(ren). We are required by law to maintain the confidentiality of health information that identifies you and/or your child(ren). We also are required by law to provide you with this notice of our legal duties and the privacy practice that we maintain in our practice concerning you and/or your child(ren) IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose you and/or your child(ren) IIHI
- You and/or your child(ren) privacy rights in you and/or your child(ren) IIHI
- Our obligations concerning the use and disclosure of you and/or your child(ren) IIHI

The terms of this notice apply to all records containing you and/or your child(ren) IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintain in the past, and for any of you and/or your child(ren) records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. We may use and disclose you and/or your child(ren) IIHI in the following ways:

1. **Treatment:** Our practice may use you and/or your child(ren) IIHI to treat you and/or your child(ren).
2. **Payment:** our practice may use and disclose you and/or your child(ren) IIHI in order to bill and collect payment for the services and items you and/or your child(ren) may receive from us. For example, we may contact your health insurer to certify that you and/or your child(ren) are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding you and/or your child(ren) treatment to determine if your insurer will cover, or pay for, you and/or your child(ren) treatment. We also may use and disclose you and/or your child(ren) IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use you and/or your child(ren) IIHI to bill you directly for services and items.
3. **Appointment Reminders:** Our practice may use and disclose you and/or your child(ren) IIHI to contact you and remind you of an appointment. We may leave a message on your answering machine, email about you and/or your child(ren) appointment, which ever you authorize.
4. **Disclosure Required by Law:** Our practice will use and disclose your child(ren) IIHI when we are required to do so by federal, state or local law.

C. - Use and disclosure of your IIHI in certain special circumstances.
The following categories describe unique scenarios in which we may use or disclose your IIHI:

1. **Public Health Risk:** Our practice may disclose you and/or your child(ren) IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding a potential risk for spreading or contacting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals if a product or device they may be using has been recalled
    - Notifying appropriate government agency(ies) and authority(ies) regarding potential abuse or neglect of an adult/ child(ren) patient (including domestic violence): however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

2. **Lawsuits and Similar Proceedings:** Our practice may use and disclose you and/or your child(ren) IIHI in response to a court or administrative order, if you and/or your child(ren) are involved in a lawsuit or similar proceeding. We also may disclose you and/or your child (ren) IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. **Law Enforcement:** We may release IIHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our office, including returned checks (nono sufficient funds)
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or description, identity or location of the perpetrator)
4. **Serious Threats To Health or Safety:** Our practice may use and disclose you and/or your child(ren) IIHI when necessary to reduce or prevent a serious threat to you and/or your child(ren) health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the treat.

D. Your Rights Regarding your IIHI

1. **Confidential communications:** You have the right to request that our practice communicate with you about you and/or your child (ren) health and related issued in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, **you must make a written request to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable request. You do not need to give a reason for your request.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your child(ren) IHII for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your child(ren)IIHI to only certain individuals involved in your child(ren) care or the payment for your child(ren) care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child(ren). In order to request a restriction in our use or disclosure of your child(ren) IIHI, **you must make your request in writing to Privacy Officer: PO Box 31447, Myrtle Beach, SC 29588.** Your request must describe in a clear and concise fashion:
    a. The information you wish restricted
    b. Whether you are requesting to limit our practice's use, disclosure or both
    c. To whom you want the limits to apply
3. **Inspection and copies:** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you and/or your child(ren), including patient medical records and billing records, but not including psychotherapy notes. **You must submit your request in writing to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077** in order to inspect and/or obtain a copy of you and/or your child(ren) IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment:** You may ask us to amend you and/or your child(ren) IIHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, **your request must be made in writing and submitted to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077.** You must provide us with a reason that supports your request for amendment. **Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing.** Also, we may deny your request if you ask us to amend information that is in our opinion; (a) accurate and complete, (b) not part of the IIHI kept by or for the practice, (c) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of disclosures:** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of you and/or your child (ren) IIHI for non-treatment, non-payment or non-operations purposes. The use of you and/or your child(ren) IIHI as part of the routine patient care in our practice is not required to be documented. For example, the provider shares information with the clinical staff, or billing department using your information to file you and/or your child(ren) insurance claim. In order to obtain an accounting of disclosures**, you must submit your request to Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077**. **All requests for an "accounting of disclosures" must state a time period, which may not be longer than 6 (six) years from the date of disclosure and may not include dates before October 2010.** The first list you request within a 12-monht period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before your incur any costs.
6. **Right to a paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact the **Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077**
7. **Right to File a Complaint:** If you believe you and/or your child(ren) privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice**,** contact the **Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077. All complaints must be submitted in writing. <u>You will not be penalized for filing a complaint</u>**.
8. **Right to Provide an Authorization for Other Uses and Disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you and/or your child(ren) IIHI may be revoked at any time in **<u>writing</u>**. After you revoke your authorization, we will no longer use or disclose you and/or your child(ren) IIHI for the reasons described in the authorization. Please note we are required to retain records of you and/or your child(ren) care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the **Privacy Officer, PO Box 31447, Myrtle Beach, SC 29588, O: 843.273.0077**