PATIENT REGISTRATION

Patient Information

Patient Name: ____ Nickname: ______________
Last First MI

Date of Birth: ______________ Gender: Male Female Marital Status: S M W D Social Security #: ______________

Address: ______________________ Apt# City: ______________ State: _____ Zip: ________

Patient: Home # ____________ Cell # ______________ Work # ____________ Ext: _____

Employment Status: Full-Time Part-Time Student Other Employer's Name: ______________________

Emergency Contact (Name): ______________________ Phone #: ______________

Relationship to patient: ______________________

Choose *one* type of appointment reminder you prefer:

- ☐ Email: Email Address: ______________________
- ☐ Text (Requires Cell Phone Number): ______________________
- ☐ Phone Call (Requires Phone Number): ______________________
- ☐ None (No Reminder)

Billing Information

Responsible Party (who pays the bill?)

Name: ________________________________ Phone #: ______________
Last First MI

Social Security #: ______________ Relationship to patient: ______________

Billing Address: ______________ City: ______________ State: _____ Zip: _______

Insurance Information

Primary Insurance Company: ______________________ Ins. Phone # ______________

Insurance I.D. # ______________ Group # ________ Social Security # ______________

Insured Name: ______________ Date of Birth ________ Employer: ______________

Address: ______________ Apt # City: ______________ State ______ Zip: ______

Insured Phone # ______________ Employer: ______________________

Secondary Insurance Company: ______________________ Ins. Phone # ______________

Insurance I.D. # ______________ Group # ________ Social Security # ______________

Insured Name: ______________ Date of Birth ________ Employer: ______________

Address: ______________ Apt # City: ______________ State ______ Zip: ______

Insured Phone # ______________ Employer: ______________________

The above information is correct and I give permission for the office to make appointment reminders as indicated above.

Patient/Guardian Signature ______________________________ ***Date:*** __________

PATIENT REGISTRATION

Consent for Treatment

Client Name:_______________________________

Release of Information & Assignment of Benefits: I have received and read the clinic's Financial Policy and Fee Schedule. I hereby authorize Comprehensive Counseling Services to release to my insurance company and/or associated professionals any information from my medical records that may be necessary to determine benefits payable under my policy. I understand that this information which may be transmitted electronically, may include the diagnosis and treatment of mental illness including alcohol and drug abuse, and developmental disabilities, and may include progress notes of my treatment.

Assignment of Benefits: I authorize payment directly to Comprehensive Counseling Services for the benefits otherwise payable to me for the amount that covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. **I understand that I may be charged $75.00 for missed appointments as defined in the Financial Policy if not cancelled at least 24 hours prior to the appointment time.** I further understand that all co-payments are due at the time of service and that I am responsible for all balances to be paid within 90 days of the date of service regardless of the status of the insurance claims.

Patient Rights and Confidentiality: Your treatment is a private and personal relationship between you and your provider. Within our clinic, your provider may review your treatment with a clinical consultation team including other behavioral health providers in the clinic. We will only release information about your treatment with your written consent, except in situations that are required by law. By law, we must release information in situations of: (1) abuse or neglect of children; (2) abuse or neglect of the elderly; or (3) cases of probable suicide (self-harm) or homicide. In these cases, your provider may need to take steps to protect people from harm or to warn them such as: (1) contacting a family member; (2) contacting a public agency; or (3) arranging for hospitalization.

Confidentiality for Parents & Minor Children: While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child aged 13 and under unless s/he agrees that we can share whatever information we consider necessary with a parent. For children 14 and older, by law, communication regarding treatment to the child's parents requires the child's agreement, unless we believe there is a safety concern (related to situations listed in the above section on exceptions to Confidentiality). In such situations, we will make every effort to notify the child of our intention to disclose information and handle any objections raised.

Consent for Treatment: I request and authorize Comprehensive Counseling Services, its staff, including psychiatrists, psychologists, and licensed psychotherapists, who may attend to me during this series of outpatient services, to provide and perform such treatment, medication, and other psychological-based interventions which are considered advisable by my treatment provider for my health and well-being. I understand that my treating provider will request my participation in developing my plan for treatment including informing me of the benefits and expected outcomes for treatment, the type of treatment, and alternative options and problems that may arise if I don't receive treatment. I further understand that Comprehensive Counseling Services cannot guarantee the outcome of the treatment provided. I have been informed of the clinic's policy on confidentiality.

I understand that this consent for treatment may be revoked by me at any time by written notice to the Clinic Director and/or my treating provider. I further understand that I am responsible for any costs incurred prior to the revocation of the consent for treatment and that any information released by my consent prior to revocation of consent for treatment cannot be retrieved. I hereby consent to treatment.

____ ______________________

Signature of Patient / Legal Guardian Date

PATIENT REGISTRATION

Informed Consent for Telehealth Services

Client Name:__________________________

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Comprehensive Counseling Services (CCS) mental health professionals to connect with individuals using secure interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

Your Rights, Benefits and Risks of Telehealth Services

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and expressed threats of self-harm or suicide. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my mental health provider, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CCS utilizes secure, HIPAA compliant, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my mental health provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health provider associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to mental health treatment through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my provider, I may be directed to “face-to-face” psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my express consent is required to forward my personally identifiable information to a third party.
8. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state of Wisconsin.
9. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand that a crisis or emergency during the course of a telehealth session may require my provider to contact a family member or legal authority to check on my safety.

PATIENT REGISTRATION

Payment for Telehealth Services
I understand that telehealth services are charged at the same rate as face-to-face services provided in the office as listed in the clinic's Financial Policy and Fee Schedule. I hereby authorize Comprehensive Counseling Services to bill my insurance company and release to my insurance company any information from my medical records that may be necessary to determine benefits payable under my policy for telehealth services. I understand that this information which may be transmitted electronically, may include the diagnosis and treatment of mental illness including alcohol and drug abuse, and developmental disabilities. I authorize payment directly to Comprehensive Counseling Services for the benefits otherwise payable to me for the amount that covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. **I understand that I may be charged $75.00 for missed telehealth appointments as defined in the Financial Policy if not cancelled at least 24 hours prior to the appointment time.** I further understand that all co-payments are due at the time of service and that I am responsible for all balances to be paid within 90 days of the date of service regardless of the status of the insurance claims.

Patient Consent to the Use of Telehealth I have read and understand the information provided above regarding telehealth, have discussed it with my mental health provider, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

____
Client Name

______________________________________ ____________________
Signature of Client Date

______________________________________ ____________________
Signature of Parent / Legal Guardian Date

PATIENT REGISTRATION

Notice of Privacy Practices

Client Name:________________________________

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.

"Protected Health Information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care. This Notice describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and describes your rights regarding how you may control your PHI.

Your Rights Regarding your PHI

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

● You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
● We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

● You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
● We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communication

● You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

● You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
● If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

● You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
● We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you

● If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
● We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

● You can complain if you feel we have violated your rights by contacting the Clinic Director at Comprehensive Counseling Services.
● You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
● We will not retaliate against you for filing a complaint.

PATIENT REGISTRATION

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
● Share information with your family, close friends, or others involved in your care with your written permission. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission.

Other Uses or Disclosures

With your written permission, we typically use or share your health information in the following ways:

Treat you
● We can use your health information and share it with other professionals who are treating you (such as your primary care physician). We require your written permission to share your information with other professionals.
● We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for services
● We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Comply with the law
● We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:
● For workers' compensation claims
● For law enforcement purposes or with a law enforcement official
● With health oversight agencies for activities authorized by law

Respond to lawsuits and legal actions
● We can share health information about you in response to a court or administrative order

Our Responsibilities
● We are required by law to maintain the privacy and security of your protected health information.
● We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
● We must follow the duties and privacy practices described in this notice and give you a copy of it.
● We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By placing your signature below, you attest that you have read and understand your rights and responsibilities under federal law regarding your PHI.

____ ____________________
Signature of Patient / Legal Guardian Date

PATIENT REGISTRATION

FINANCIAL POLICY & FEE SCHEDULE

Comprehensive Counseling Services cooperates in accepting third party reimbursement from our patient's insurance carriers.

Health Insurance

Your health insurance is a contract between you and your insurance company and should be viewed as a method to help pay for medical care. As a service to you, we will contact your insurance company prior to your first appointment in an attempt verify your insurance benefits (if you provide us with the information before you come in). Please keep in mind that insurance companies DO NOT guarantee payment for services over the phone, and you are ultimately responsible for any expenses incurred if your insurance does not pay what you expected they would. It is in your best interest to be aware of your outpatient mental health benefits before you come in for your first appointment. We will submit claims to your insurance company if you provide us with current insurance information. Depending on the insurance company, our fees may or may not be considered usual and customary. Insurance companies use many different equations to form a fee schedule.
Our clinic policy requires that all anticipated co-pays and visit fees be collected at the time of service. These payments may be applied against applicable unmet deductibles. If your insurance pays more than anticipated, your account will be credited. We accept cash, personal checks, and credit cards (Visa, MasterCard, Novus/Discover). The clinic charges a $30 fee to you for any NSF (non-sufficient funds) checks received, which is payable before or at the time of your next scheduled appointment. The patient is ultimately responsible for timely payment of services rendered. Any account balances outstanding after 90 days are due in full by the patient. It is the patient's responsibility to negotiate with the insurance company for any unpaid services.

Private Pay

If you are paying for visits privately (not through an insurance company), our clinic policy requires payment at the time of service. Acceptable methods of payment are cash, check or credit card. Please be prepared to make payment at the time of your visit. If you have questions regarding clinic fees and discounts available to private pay patients, please contact our office staff.

Late Cancelled Appointments and Failure to Show for Appointments

Our clinic policy requires 24 hours' notice for cancellation of any appointment. You may call our office staff to cancel, or you may, after hours or on weekends, leave a message in the clinic voice mail system; our voice mail is time-stamped. **If cancellation of an appointment is not received on time, a $75 late cancellation fee may be added to your account, payment of which is due before or at the time of your next scheduled appointment. Additionally, if you fail to show for a scheduled appointment, the same charge applies.**

Failure to Pay

Our staff of mental health providers and receptionist staff provide confidential, compassionate, and effective care to our patients and serve your needs in good faith. In order to continue to provide these services for you and other individuals in our community, we expect payment for services rendered in a prompt manner. If extenuating circumstances arise, please consult with our billing staff regarding an acceptable payment arrangement. Failure to do so may result in your account being sent to our collection agency and the need to curtail further treatment sessions until the financial situation is resolved or discharge from the clinic.

PATIENT REGISTRATION

Fee Schedule Information

The following is the fee schedule for outpatient services at Comprehensive Counseling Services:

Description	Time	Code	Masters
Diagnostic Interview (Evaluation)	45-60 mins	90791	$200.00
Psychotherapy	30 mins	90832	$84.00
Psychotherapy	45 mins	90834	$136.00
Psychotherapy	60 mins	90837	$180.00
Psychotherapy for Crisis, Initial	30-60 mins	90839	$200.00
Psychotherapy for Crisis, additional time	Additional	90840	$84.00
EAP – Preventive Counseling	45-60 mins	99404	$136.00
Family Psychotherapy w/o Patient Present	45-60 mins	90846	$136.00
Family Psychotherapy w/ Patient	45-60 mins	90847	$136.00
Group Psychotherapy*	45-90 mins	90853	$84.00
Interactive Complexity**	Additional	90785	$16.00
Psychological Testing	60 mins	96101	
No Show / Late Cancel Fee			$75.00
Miscellaneous Charges	There may be fees for telephone calls or consultations (longer than 15 minutes), consultations with schools or medical personnel, preparation of reports for legal cases, extensive copying of records. Please consult your doctor/therapist or office staff with questions.		

*Group Psychotherapy: There may be an additional fee for group materials which is not billable to insurance.

**Interactive Complexity: This fee is charged when there are factors complicating the treatment of the session and the fee is in addition to the regular evaluation and management or psychotherapy codes.

Comprehensive Counseling Services cooperates in accepting third party reimbursement from our patient's insurance carriers. We ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided. <u>You are ultimately responsible for payment of any services not covered by your insurance</u>.

It is important that you attend every scheduled session with your provider to get the most benefit from treatment. If you must cancel, please contact our office at least 24 hours in advance or you may be charged for the session. If you do not call to cancel an appointment and do not show, <u>you may be charged for the missed session</u>. It is important to note that insurance carriers do not pay for missed sessions.