Hope Counseling

Patient Registration

Patient Name: _____Date of Birth:_____

SSN: _____ Gender: ___Male ___Female

Address: _____

City: State: Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Preferred form of communication:_____

Is patient a minor/ dependent?_____

Responsible Party Name:_____Relationship to Patient___ _____

Primary Insurance: _____ID#_____

Group #:_____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Secondary Insurance, if applicable: _____ ID#_____

Group #:_____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Relationship to Patient: _____

Emergency Contact:

Name: _____Relationship to Patient:_____

Home Phone: _____ Cell Phone:_____

Work Phone:_____

Referring Physician:_____

Responsibility Party Signature: _____

TELEHEALTH SERVICES

To use telehealth, you will need an Internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your provider will recommend a different option. There are some risks and benefits to using telehealth:

RISKS TO TELEHEALTH

- **Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.**
- **Technology. At times, you could have problems with your Internet, video, or sound if you have issues during this session, your provider will follow the backup plan that you agree to prior to sessions.**
- **Crisis management. It may be difficult for your provider to provide immediate support during an emergency or crisis. You and your provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.**
- **Certain issues / treatments may not be therapeutically appropriate for telehealth. ALL CLIENTS WILL BE ASKED TO PARTICIATE IN-PERSON FOR A BIOPSYCHOSOCIAL ASSESSMENT BEFORE TELEHEALTH IS APPROVED.**

RECOMMENDATIONS FOR SUCCESSFUL TELEHEALTH

- **Make sure that other people cannot hear your conversation or see your screen during sessions. Eliminate distractions to the best of your ability as if you were in a therapy office.**
- **DO NOT use video or audio to RECORD your session.**
- **Make sure to let your provider know if you are not in your usual location BEFORE starting any telehealth session. Certain location changes may result in a cancelation of session and may also result in a missed session fee.**

CHILD CARE

____ I understand that Erin Adams, LLC/ Hope Counseling are unable to provide child care. I understand that it is not appropriate to bring children into individual or marital counseling sessions. Often session content is not appropriate for children to be a part of and the presence of children inhibits full focus on the work of therapy. Minors under the age of 17 may not be left unattended without prior arrangements establish with your Provider. Therapy sessions will be cancelled or rescheduled and will include a late cancel fee if children are brought to sessions without prior approval.

NO SHOWS, LATE CANCELATIONS AND OUTSTANDING BILLS

____ I understand that if I do not give 24 hour notice of cancellation or if I have a no show for an appointment I will be charged the late cancellation rate of $75. This fee is the responsibility of the client as insurance will not cover missed services. Should I fail to cancel my appointment 24 hours BEFORE a scheduled session or do not attend the session at all, I agree that my credit card on file will be charged for this fee.

____ understand that all outstanding bills must be paid in full prior to setting up any further appointments with my counselor. All appointments will be placed on hold until outstanding balances are paid.

____ I understand that if I no show for more than three consecutive appointments my counselor reserves the right to refer me to another counseling office.

____ I understand that if my credit card on file fails or declines payment that my appointment(s) may be cancelled / rescheduled.

____ I understand that a grace period of up to 15 minutes will be extended for the start of therapy sessions. Due to limitations of many insurance companies, sessions (for adults) shorter than 45 minutes often cannot be billed. If you arrive later than 15 minutes past the start time of your session, your session may be canceled and you billed the late cancel fee of $75.

Hope Counseling
CENTER OF SAVANNAH

Informed Consent for Treatment

Patient Name: _____ Date: _____

I, _____, agree and consent to participate in behavioral/mental health care services offered and provided at/by The Hope Counseling Center. I understand that I am consenting and agreeing only to those services that the above-named center is qualified to perform within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral/mental health providers directly supervising the services received.

Signature: _____ Date: _____

Confidentiality

The staff of The Hope Counseling Center is dedicated to keeping information shared within your sessions private and confidential. In the event that we are billing a third-party, we must provide certain information concerning services rendered, diagnosis and you or your child's identity. If requested to release information with other entities/agencies, we will require a written consent.

Limits of Confidentiality

The following limits to confidentially apply:

1. We are required by law to report suspicions of child physical and /or sexual abuse or neglect
2. We are required by law to report homicidal or suicidal intent.
3. In the event of subpoena by a court, we are required to provide requested documents

Please ask for clarification if you misunderstand anything you have read in this material. Your signature below indicates that you have read and fully understand this document.

Signature:_____Date:_____

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

I authorize The Hope Counseling Center to release information about me, which may be necessary to my insurance company regarding services, which may be covered by my policy. Insurance payments, if any, will be made directly to the The Hope Counseling Center. A copy of this authorization may be used in the place of the original.

Signature:_____Date:_____

Hope Counseling
CENTER OF SAVANNAH

HIPAA 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 and for other purposes that are permitted or required by law. It also describes your rights to access and control you protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and relates 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 physician, our office staff 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 physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or 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. Your protected health information may be provided to a physician to whom you have been referred to ensure 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 may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of interns, licensing, marketing and fund-raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to interns that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when Lorraine 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. These situations include: as required by Law; public health issues as required by law. Communicable Diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements. Legal Proceedings; Law Enforcement, Coroners, funeral Directors, and Organ Donation. Research, Criminal, Military Activity, and National Security, Workers Compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or

determine our compliance with the requirements of Section 64.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent. Authorization or Opportunity to Object unless required by law:

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

37 West Fairmont Avenue #201 Savannah, Ga. 31406

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following: psychotherapy notes, information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You will then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us be alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Hope Counseling
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Member's Rights and Responsibilities Statement of Member's Rights:

- Be treated with dignity and respect
- Fair treatment; regardless of race, religion, gender, ethnicity, age, disability or source of payment
- Treatment and other member information kept private. Only when permitted by law, may records be released without member permission.
- Easily accessed timely care in a timely fashion.
- Know about treatment choices. This is regardless of cost or insurance coverage by a member's benefit plan.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines uses in providing and managing care.
- Ask their provider about their work history and training.
- Give input on the Member's Rights and Responsibility policy.
- Give input on the Member's Rights and Responsibilities policy
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and learn how to do so.
- Know of their rights and responsibilities in the treatment processes.
- Receive services that will not jeopardize their employment.
- Request certain providers.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Member's Responsibilities:

- Treat those giving them care with dignity and respect.
- Give providers information they need, this is to ensure that providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The treatment plan is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given by them by others.
- Keep their appointments. Members should call their provider as soon as they know they need to cancel visits.
- Let their provider know about problems with paying fees.
- Report fraud and abuse.
- Openly report concerns about the quality of care they receive.

Hope Counseling
CENTER OF SAVANNAH

Signature Form

Patient Name: _____

Date: _____

I, (parent/guardian if patient is under 18), acknowledge that I received a copy of the Member's Rights and Responsibilities Statement as well as the Informed Consent policy. Please ask for clarification if you misunderstand anything you have read in the material. Your signature below indicates that you have read and fully understand these documents.

Signature: _____

Date: _____

Hope Counseling
CENTER OF SAVANNAH

Insurance Verification Sheet

Please call your insurance company prior to your initial appointment. On the back of your card (typically) locate the telephone number provided for Mental Health/Substance Abuse and/or behavioral Health.

Patient Name:_____DOB: _____
Insured's ID:_____Group ID: _____Effective Date: _____
Insurance Name:_____Telephone: _____
Please make sure to request outpatient mental health benefits when calling. Ask and complete the following:

Does your plan cover counseling by a Licensed Professional Counselor'* _____
is the provider you are scheduled to sec (e.g., Bonnie Craven Glenn, Andrea Liverman, Erin Adams, or Leslie Pegram) an in-network provider? ___

If not, ask if your plan for out-of-network benefits:_____Is there a deductible? _____
If so, have you met the deductible? _____
What percentage of the deductible has been met? _____
What is your copay or percentage you are expected to pay? _____
Docs your plan cover family therapy (CPT Codes 90847 or 90846)? _____
Is there a limit on visits per year? If so, how many visits per year are you issued? _____
How many visits have you used?_____Do the service limits run per traditional calendar year?_____If not, how does the year run? _____
Do outpatient mental health services require authorization?_____Is a treatment plan required? _____

If authorization is required and you are planning on family therapy, or if the patient is a minor, please inform the insurance company that you are requesting family and individual visits.
If any services you are requesting require authorization, please obtain the authorization number and list here: Auth Number. _____
Effective dates: from_____to_____
Auth good for how many sessions_____
Are there any mental health diagnoses excluded under your mental health plan, related to your presenting concerns (e.g., depression, ADHD, Autism Spectrum Disorder, etc.?)
Inquire regarding a submittal address for mental health services (this is not always the same as what's shown on your card) _____
Name of representative you spoke with:_____Date of call: _____

Signed:_____Date: _____

37 West Fairmont Ave #201 Savannah, Ga. 31406, Ph: 912-661-2801, Fax: 1-800-615-5428

Hope Counseling
CENTER OF SAVANNAH

Fees for Service
Information

Please review the following fees for service:
*Initial Intake Session: $ 175.00 self-pay
*Individual Counseling Session (60 minutes): $150.00 self-pay
*Intake and Individual Counseling Sessions with insurance: $225 billed to company, copay/deductible vary based on coverage
*Missed/Canceled w/o 24 hr. notice $75.00

Please note each session will be billed according to the above referenced fee schedule (fees are subject to change). Increments will be added for each additional quarter hour and additional fees may be applied for crisis appointments. Payments and copays are due and are accepted prior to the beginning of each session. Payments are expected at the time service is rendered. No further sessions will be scheduled if balances are not current. We accept cash, check or credit cards (Visa, Mastercard, Discover and American Express).

If your provider is in-network with your insurance carrier, our office will gladly file insurance claims for you and the contractual amount for reimbursements will be accepted. For insurances that are considered out of network, full payment of fees is expected at the time of service and a HCFA form can be provided to you if you would like to seek reimbursement on your own behalf.

Please acknowledge, in the event of non-payment, your account will be turned over to an outside collection agency and by signing below you agree to pay all reasonable collection fees.

Please note it is a courtesy of our office to check benefits prior to your initial appointment. However, the benefits quoted to our office will only be an estimate of the reimbursement rate as payment is determined by your insurance at the time of claim review. By signing below, you agree to verify your benefits prior to your initial appointment to determine a reimbursement quote. The insurance benefit verification sheet provided will be helpful in obtaining the necessary information for expected reimbursement for your therapeutic services. Please complete and bring with you to your initial appointment.

By signing below, you acknowledge that you are financially responsible for services rendered and have been made fully aware of the insurance policies regarding fee payment and recommended procedures for benefit verification.

Signed:_____Date: _____

Hope Counseling
CENTER OF SAVANNAH

Credit Card Form

Client Name: _____
Today's Date: _____
Cardholder Name: _____
Type of card:(AmEx, Visa, etc.) _____
Card Number: _____
Expiration Date (oo/oooo): _____
CVC code: _____ Billing zip code: _____

I, _____authorize the use of this credit card without my presence when utilized for outstanding balances associated with services provided by Hope Counseling Center and staff including the following: Co-pay, Co-insurances, Self-Pay fees, No Show fees, and cancellations fees and fees not paid by my insurance company.

Cardholder Signature:
_____

Date: _____
Relationship to Client: _____

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CENTER OF SAVANNAH

Note which areas apply with a check and the severity of the symptoms as well as the last time the symptoms occurred.

History of presenting problem(s)/concern(s)	*Yes*	*No*	*Frequency*
a) Problems experienced at home/work/school			
b) Any loss of interest in activities and/or energy			
c) Trouble focusing on a task/project/idea			
d) Sleeping disturbances (restless/insomnia/			
e) Social isolation/withdraw from peers			
Social and/or situational stressors			
a) Conflict within marriage/significant other			
b) History of abuse (physical/sexual)			
c) Financial concerns			
d) Significant losses			
e) Other			
Mood disturbance			
a) History of depression			
b) Crying spells			
c) Changes in eating habits			
d) Amount of weight gained or lost			
e) Irritability/outbursts			
f) Suicidal thoughts/gestures/plan/attempts			
Anxiety			
a) History of anxiety diagnosis			
b) Anxious			
c) Phobia			
d) Worrisome behaviors			
e) Panic attacks			
f) Obsessive/compulsive behaviors			
ADHD			
a) History of ADHD diagnosis			
b) Impulsiveness			
c) Easily distracted			
d) Academic difficulties			
Autism			
a) History of Autism diagnosis			
b) Developmental concerns			
c) Poor social skills			

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Previous Medical History:

Allergies:_____

Primary Care Physician's Name and Phone #:_____

Date of the last Physical Exam:_____

Results of the Exam:_____

Revelant Medical Conditions:_____

Current Medications:_____

Recent and Past Hospitaliztions and Surgeries:_____

Past Psychiatric History

Hospitalizations:_____

Prior Outpatient Therapy:_____

Prior Inpatient Therapy:_____

Previous Clinicans and date of services:_____

Prior response to Treatment including medications:_____

Mental Health History of Family Members:_____

Substance Abuse History of Family Members:_____

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Family Members Residing in the Household

Name:	Age:	Sex:	Relationship:

Signature: Date:

37 West Fairmont Ave #201 Savannah, Ga. 31406
Phone: 1-912-661-2801, Fax: 1-800-615-5428
www.hopecounseling.center

Telemedicine Informed Consent Form

I_____hereby consent to engaging in teletherapy with my existing therapist at Hope Counseling Center. I understand that "teletherapy" includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually, to Hope Counseling Center of Savannah via the teletherapy service, Doxy.me (a HIPAA compliant video platform service).

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

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy 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 towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Georgia law.

(6) I understand that, per the ethical guidelines of the state of Georgia teletherapy services can ONLY be provided to those residing in the state of Georgia at the time of service.

(7) I also understand that teletherapy is not always a covered service by my insurance plan, and it is my responsibility to check with my individual plan to determine if teletherapy is authorized. The patient will ultimately be responsible for all fees related to teletherapy that insurance does not cover.

(8) Teletherapy will be billed at the same rate of individual therapy services.

(9) Teletherapy is a temporary service that is being offered to all Hope Counseling clients due to extreme circumstances as a precautionary measure. Once these circumstances abate, therapy sessions will return to in-person services as previously scheduled. Please contact your therapist directly if you have any questions.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature of Patient

Printed name of Patient

Date

Signature of psychotherapist

Hope Counseling Center of Savannah

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

Hope Counseling has put in place preventative measures to reduce the spread of COVID-19; however, Hope Counseling Center **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments with your therapist **could increase your risk** and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments at Hope Counseling Center and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at t Hope Counseling Center may result from the actions, omissions, or negligence of myself and others, including, but not limited to Hope Counseling Center, their employees, volunteers, and other participants and their families. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments at Hope Counseling Center. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless Hope Counseling Center, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Hope Counseling Center, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments at Hope Counseling Center.

Name of Client/ Name of parent or guardian if applicable

_____ _____

Date **Signature of client/parent/guardian**