CHEAHA
COUNSELING
& CONSULTING

APPLICATION

Today's Date: _____

Client Name: _____

SS#: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____

May we send mail to the above address? _____YES _____ NO

Phone #: _____ Alternate #: _____

Work #: _____

May we leave messages on any above numbers? _____YES _____ NO

Emergency Contact: _____ Relationship: _____

Contact Phone #: _____

May we leave messages with person listed? _____YES _____ NO

If you are participating in counseling services because of an open case with DHR, please complete the following section:

DHR Social Worker: _____

What county is your case in? _____

Please list the names and ages of all children involved with your case?

_____ _____

_____ _____

_____ _____

RELEASE OF INFORMATION FOR THE DEPARTMENT OF HUMAN RESOURCES

Name: _____ Date: _____

By signing below, I authorize Cheaha Counseling and Consulting to release information to The Department of Human resources about my case which includes progress notes and assessments for each counseling session. I also authorize The Department of Human resources to release all information regarding my case to Cheaha Counseling and Consulting. I am also aware that Cheaha Counseling and Consulting will be billing DHR for services performed and I will not receive a bill for those specific services, but I could be billed for services not authorized by DHR or for request of records outside the scope of my involvement with DHR.

Signature: _____ Date: _____

Witness: _____ Date: _____

INSURANCE INFORMATION

Person responsible for the bill _____

Birth Date _____

Address if different than above_____

Home phone_____

Employer_____

Employer Address_____

Employer phone number_____

INSURANCE INFORMATION CONTINUED

Primary Insurance:_____

Subscriber's name_____ Subscriber's SS#_____

Policy number _____ Birth Date_____

Group number_____ Co-payment_____

Patient's relationship to subscriber_____

Any current mental/emotional diagnosis of patient_____

Current Medication_____

_____

_____

USE OF INSURANCE AGREEMENT

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an “illness” before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Client_____Date_____

Fee Agreement and Polices

Cheaha Counseling and Consulting

1. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. It is your responsibility to know any stipulations of your insurance such as co-pay amount, need for referral forms, deductibles, and need for treatment pre-authorization. For example, your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations otherwise you will be responsible for the payment. In addition, you will need to keep track of the number of sessions allowed; if this amount is exceeded you will be responsible for the payment.

2. Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I prefer that all such work be done in your session so that you are fully aware of and can participate in what is written. If you give me the paperwork at the end of a session, I may not be able to complete it during the session, and I charge for paperwork that is done outside of sessions.

3. Please inform your counselor immediately of any change in insurance coverage, employment, address, and phone numbers. Changes in insurance coverage could result in your sessions not being reimbursed by your insurance company, and then you would be responsible for the charges.

4. Co-payments, in the form of cash, credit, or check, are due at the beginning of each session. There is a $30 charge for a returned check.

5. Your appointment time is reserved for you; Cheaha Counseling does not double book appointments. Therefore, Cheaha Counseling will charge you if you fail to show up for an appointment or if you cancel less than 24 hours before the appointment. You will be billed for the session ($130.00) since this charge cannot be billed to your insurance company.

6. If you are paying out of pocket, an initial session (lasting 1 hour) will cost $130 and each follow-up sessions (50 minutes) will cost $130.

7. Other expenses:

A. For unpaid charges over 30 days old (from the date of the first billing), a service fee of 2% of the balance per month will be applied. A past due account may cause interruption of service.

B. $25.00 for paperwork completed outside of a session.

C. $100.00 for a written report for any purpose (this fee must be paid before the report is released to you).

D. $25.00 (per call) for a phone call lasting longer than 15 minutes and any email (per email) that requires a response outside of normal office hours (office hours are 8:00 A.M. to 5:00 P.M.)

E. $140.00 for consultation or review of records.

F. Records request fees (Alabama law. Section 12-21-6.1 Alabama Code Reproduction)

The reasonable costs of reproducing copies of written or typed documents, or reports shall not be more than:

- **One dollar ($1) for each page of the first 25 pages**
- **Not more than 50 cents ($0.50) for each page in excess of 25 pages**
- **A search fee of five dollars ($5)**
- **If the medical records are mailed to the person making the request, reasonable costs shall include the actual costs of mailing the medical records.**

The therapist at Cheaha Counseling and Consulting will not appear in court for any issues related to custody, subpoena of records, and any private court matter that does not involve DHR.

I have read the above information and understand the fees and polices of Cheaha Counseling and Consulting. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

Client Signature **Date**

DUTY TO WARN

Although confidentiality and privileged communication remain rights of all clients of mental health practitioners according to the law, some courts have held that if any individual intends to take harmful acts or dangerous action against another human being, or against themselves, it is the practitioner's DUTY TO WARN the person or family of the person who is likely to suffer the results of any harmful behavior to someone or themselves with such intention.

I, as a mental health practitioner, will under no circumstances inform such individuals without first sharing that intention with the client, unless it is not possible to do so. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.

Counselor's Signature: _____ Date: _____

I have read the above statement and understand the therapist's social responsibility to make such decisions if and when necessary.

Signature: _____ Date: _____

SOCIAL MEDIA/ SURVALIENCE CONSENT

I understand that any communication through text and/ or email is not a secure way of communication and could compromise my confidentiality. It may also create the possibility that these changes become a part of my legal medical record and will need to be documented and archived in my chart as seen necessary of my therapist. Also, I understand that business

cameras are set up for the protection of the business and business only. All personal records written/ verbal are strictly confidential. Cheaha Counseling and Consulting is a non-recording mental health facility and unless authorized in writing no recordings are allowed.

Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Office and HIPPA Policies

I hereby acknowledge receipt of Cheaha Counseling & Consulting

Notice of Office and HIPPA Policies

_____ _____

Printed Name Date

_____ _____

Signature of Patient/ Personal Representative Date

Relationship to Client (Circle One) Self Parent Guardian Other _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO HIPPA

Name: _____ Date of Birth: _____

Address: _____

I, or my authorized representative, request that mental health information regarding my care and treatment be released as set forth on this form:

1. I understand that signing this authorization is voluntary. My treatment, payment, and/ or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

2. I understand that I have a right to refuse to sign this authorization.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that I have a right to receive a copy of this authorization.

5. I understand that this information may be protected by Title 42 (Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

6. I understand this authorization may include disclosure of information relating to Alcohol and Drug abuse, mental health treatment, except Psychotherapy notes, and CONFIDENTIAL related information

7. I understand this authorization of release will expire ONE YEAR from the date signed.

8. This authorization DOES NOT authorize you to discuss my health information or medical care with anyone other than the Individual(s) listed below.

I hereby authorize CHEAHA COUNSELING & CONSULTING, LLC (therapist as well as any and all staff) to release my information to the following.

Name:_____ Phone: _____

Address: _____

_____ Entire Medical Record, including patient histories, office notes (except psychotherapy note), test results, assessments, letters, emails, consults, billing records, etc.

_____ Other _____

Information Excluded from the Right of Access

An individual does not have a right to access PHI that is not part of a designated record set because the information is not used to make decisions about individuals. This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions more generally rather than to make decisions about individuals. For example, a hospital's peer review files or practitioner or provider performance evaluations, or a health plan's quality control records that are used to improve customer service or formulary development records, may be generated from and include an individual's PHI but might not be in the covered entity's designated record set and subject to access by the individual.

In addition, two categories of information are expressly excluded from the right of access:

- **Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501.**

- **Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).**

However, the underlying PHI from the individual's medical or payment records or other records used to generate the above types of excluded records or information remains part of the designated record set and subject to access by the individual.

Signature: _____ Date: _____

Witness: _____ Date: _____