GAINESVILLE PROFESSIONAL COUNSELING CENTER

INSURANCE INFORMATION

This information must be obtained prior to your initial appointment.

When you call you insurance company, please specify that you need your outpatient mental health benefits.

Name of Insurance Carrier:_____

Please be aware that your medical insurance provider may not be the same insurance company contracted for your mental health benefits.

Insurance Contact Number: _____

Questions to ask:

*****Electronic Payer ID #_____**

*****Is Tele-health covered?*** ◯Y ◯N

Do I need Pre-Authorization? If so, Authorization# _____

Do I have an annual deductible? ◯Y ◯N If yes, amount: $_____

Have I met my deductible? ◯Y ◯N If no, how much is left? $_____

Co-pay Amount: $_____

Number of visits allowed? _____ Is my visit limit per calendar year or contract year?_____

If contract year, when does my contract year start?_____

Does my therapist have to complete any treatment requests? ◯Y ◯N
If yes, after how many visits?

Claims Address:

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Registration Form

Today's Date How did you hear about us? :

Patient's full name:

Home Address:

City: State: Zip: Home Phone:

CELL PHONE: Sex: Age: DOB:

Present Employer: Work Phone:

E-Mail address: Alt Contact PH:

Emergency Contact: Relationship: PH:

INSURED/RESPONSIBLE PARTY INFORMATION

Name of Insured: Relationship to client: DOB:

Home Address:

Phone: Social Security Number:

Employer Name: Phone:

Primary Insurance: ID#: Group#:

BILLING AND INSURANCE POLICY

1. I authorize use of this form for all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I permit a copy of this form to be used in place of an original.

- It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance at the time of services rendered.
- There will be a $30 service charge on all returned checks.
- In the event that your account goes to collections, there will be a 25% collection fee added to your balance.
- There is a24-hourcancellation policy that requires that you cancel your appointment 24hours in advance to avoid being charged. Cancellations may be made by phone.

There is a $100 out-of-pocket expense for late cancellations or missed appointments.

I understand and accept all of the terms regarding billing, insurance, and cancellation policies.

_____(Signature)_____(DATE)

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TELE-HEALTH

Tele-health is available to GPCC clients. This video conferencing option will/can be used in the following circumstances:

- Contagious Illness: Should you, your child or your therapist not feel well and are unable to attend the session in person.
- Homebound: If you or your therapist may need to stay home because a child is at home due to illness.
- Inclement weather
- Reschedule Conflict: If an appointment reschedule occurs at a time your therapist does not have access to office space.
- Preferred Method to conduct session.

The platform being used is Jituzu. It is a secure HIPAA complaint platform approved by insurance companies.

These are the steps you need to take:

1. **Call** your insurance company and verify that Tele-health is covered as part of your Outpatient Mental Health Benefits. Your insurance will automatically be billed for these services. ***Should this not be verified and claim is denied, you will be responsible for paying for this service in full; out of pocket.***
2. **Activate** your Jituzu account. You will get an e-mail invitation with an invite code. After you use the code, the account will be activated.
3. **Download** the Jituzu app to any Apple or Android mobile device.

Tele-health sessions will be conducted by GPCC therapist in a private area to maintain your confidentiality.

Tele-health is being offered as a viable and secure option to keep your scheduled appointment in the event of unforeseen circumstance. Should tele-health be covered by your insurance company and you choose to voluntarily opt-out of this service; it will be treated as a Missed Appointment and the $100 out of pocket fee Missed Appointment fee will apply.

I understand and accept all of the terms regarding Tele-health billing, insurance, opt-out and cancellation policies.

_____(Signature) _____(DATE)

GAINESVILLE PROFESSIONAL COUNSELING CENTER

CREDIT CARD POLICY & AUTHORIZATION FORM

GPCC uses an online Credit Card Processing System (Jituzu). This system is secure and accepts all major CC as well as HSA accounts.
Clients will be required to place a credit/debit card on file. This card will be used for session fees as well as balances due. Balances due are attributed to outstanding balances for co-pays, deductibles, professional fees, missed appointment/late cancel fees.
The following session fees are variable and may apply based on your insurance coverage:

- Copayments (varies based on your insurances coverage)
- Deductible payments (varies based on your insurance coverage)
- Co-insurance payments (varies based on your insurance coverage)

The following fees apply when there is a missed appointment/late cancel, or professional fee and will be automatically charged to the credit card on file.

- Missed Appointment/ Late Cancel Fees ($100)
- Professional Fees are variable and are based on amount of time invested by therapist.

I understand that I can ask for an explanation and clarification of any charges incurred.
I authorize GPCC to keep my credit/debit card on file and to charge fees, as described above, to the credit/debit card listed below. *I understand that certain fees (session, missed appointment/late cancel and professional fees) will be automatically charged to the card I have placed on file*. I understand that this authorization is valid until I cancel it in writing. I will also keep my card on file updated as necessary.

_____**(Signature)** _____**(DATE)**

Cardholder Name (Please Print):

Client Name (s) (Please Print):

This information will be maintained securely. As soon as the information is entered into the system, this form will be shredded.

Cardholder Name (Please Print): _____

Card Type: ◯Visa ◯MasterCard ◯Discover ◯American Express

Account Number: _____

Expiration:

Security Code: 3 or 4 digit number on the back, usually next to your signature

Street Address: _____

City: _____ Zip Code:_____

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Background Info & Self-Assessment

Please complete the assessment below.

Name: Clients Name:

Date: Age: Marital Status:

Did another professional recommend that you or members of your family come to therapy? If yes, who?

What concerns/issues have brought you to the office today?

Who is living in your residence full time?

Name Age Relationship

Children not living at home full time:

Name Age

Do you/your child have any medial concerns, surgeries or hospitalizations either current or past? If yes, please list:

Name Condition Treating Physician

Are you/your child currently taking medication? If yes, please list:

Medication Dosage Condition Physician

Do you/your child have any Allergies? If yes, please list:

Primary Care Doctor/Referring physician: Phone:

Last physical exam:

Family History

(Have you or any biological family members had a history of:

Mental Health Issues: ◯ Y ◯ N If yes, select yourself or family member and enter condition below:

Family Member Condition(s)

Substance Abuse: ◯ Y ◯ N If yes, select yourself or family member and enter substances below:

Family Member Substance(s)used

Medical Illness: ◯ Y ◯ N If yes, select yourself or family member and enter condition below:

Family Member Condition(s)

Suicidal Thoughts: ◯ Y ◯ N If yes, select yourself or family member and enter age below:

Family Member Age

Self Harm Attempt: ◯ Y ◯ N If yes, select yourself or family member and enter type and outcome below:

Family Member Type Outcome

Homicidal Thought: ◯ Y ◯ N If yes, select yourself or family member and enter when and who below:

Family Member When Who would you harm

Abuse History:

Physical: ◯Y ◯N If yes, Age: Abuser:

Sexual: ◯Y ◯N If yes, Age: Abuser:

Emotional: ◯Y ◯N If yes, Age: Abuser:

Current use of:

Alcohol: ◯Y ◯N If yes, How often:

Drugs: ◯Y ◯N If yes, How Often:

Other Addictive Behaviors (gambling, shopping, internet, sex) ◯Y ◯N If yes, Explain below:

Current Symptoms: (check all that apply)

INDICATE DURATION OF SYMPTOMS

- ❑ Depressed (length of time___)
- ❑ Sad (length of time___)
- ❑ Hopeless(length of time___)
- ❑ Worthless (length of time___)
- ❑ Helpless(length of time___)
- ❑ Excessively or inappropriately guilty (length of time___)
- ❑ Anxious or have difficulty controlling worry(length of time:____)
- ❑ Panicky or having panic attacks (length of time___)
- ❑ A lack of interest in things you use To enjoy?(length of time___)
- ❑ Fidgety or experiencing trouble Sitting still?(length of time___)
- ❑ Tired, in slow motion or worn out? (length of time___)
- ❑ Unable to think through problems Or concentrate?(length of time__)
- ❑ Stress
- ❑ Heart pounding/racing
- ❑ Chest pain
- ❑ Trembling/shaking
- ❑ Sweating
- ❑ Chills/hot flashes
- ❑ Anger/frustration
- ❑ Isolation/social withdrawal
- ❑ Feelings of Loss
- ❑ Argumentative
- ❑ Defies rules
- ❑ Isolation/socially withdrawal
- ❑ Easily agitated

- ❑ **Change of Appetite**
  - ◯ Gain
  - ◯ Loss

  Length of time
- ❑ **Sleeping Changes**

  ☐Difficulty falling asleep
  ☐Waking up during the night
  ☐Getting up earlier than you wanted
  ☐Sleeping more than you wanted

  Length of time

- ❑ Thoughts of hurting yourself
- ❑ Thoughts of hurting someone else
- ❑ Excessive use of alcohol and/or Drugs
- ❑ Excessive use of prescription drugs
- ❑ Excessive behaviors
- ❑ Blames others
- ❑ Tingling/numbness
- ❑ Fear of dying
- ❑ Fear of losing control
- ❑ Nausea
- ❑ Phobias
- ❑ Obsessions/compulsive behaviors
- ❑ Racing thoughts
- ❑ Delusions/hallucinations
- ❑ Confusion
- ❑ Blackouts
- ❑ Feeling that you are not real
- ❑ Feeling that things around you are
- ❑ Not real
- ❑ Lose track of time/deadlines
- ❑ Persistent unpleasant thoughts
- ❑ Other issues/concerns:

How long have these issues been of concern to you?

Are any of the above issues checked caused impairment, disruption or difficulties with social relationships, academic/work performance or other important activities?
Please Explain:

Have you/your child had previous counseling? ◯Y ◯N When:

What was the duration of treatment? Was it helpful? ◯Y ◯N

Have there been any deaths or major changes (deployment, separations, job loss, moving) in the immediate family? ◯Y ◯N If yes,

Who/What: When:

TREATMENT GOALS:

What are you trying to accomplish with counseling?

Please list any concerns you have about coming to therapy

GAINESVILLE PROFESSIONAL COUNSELING CENTER

Outpatient Services Agreement

Welcome to our practice. This document contains important information about our professional services and the company's business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

THERAPEUTIC SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with you therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

CONTACTING US

Our telephone is answered by an answering service. The operator will ask questions to help pair you with the first available therapist most qualified to meet your individual needs. E-mail is used for scheduling purposes and can also expedite contact. If e-mail is not an option, we will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you

are available. If you are unable to reach us and you feel that you can't wait for us to return your call, contact your family physician, psychiatrist, or the nearest emergency room. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

SESSIONS

We normally conduct an evaluation that will last from 2-4 sessions. During this time, you and your therapist can both decide if he/she the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 45-60 minute session per week at a time we agree on. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancelation (unless you and your therapist both agree that you were unable to attend due to circumstances beyond your control). The fee for missing a scheduled appointment is $100.00.

The $100 missed appointment/late cancellation fee is an out-of pocket expense it cannot be submitted to your insurance company. You are responsible for the full amount.

PROFESSIONAL FEE (EXCLUDING LEGAL FEES)

Our Initial Appointment fee for Master's level Licensed Clinicians (LPC, LCSW, or LMFT) is $200 and all subsequent appointments are $150-$175. Fees for Master's Level Professionals who are license eligible (LMHPE) are flat fees decided on an individual case-by-case basis. In addition to weekly appointments, we charge this amount for other professional services you may require, though we will break down the hourly cost in 15 minute increments if we work for periods of less than one hour. Other services include letter writing, clinical telephone conversations lasting longer than 5 minutes, other correspondence with professionals you have authorized, preparation of records, and the time spent performing any other service you may request of us.

BILLING AND PAYMENTS

You will be expected to pay for each session/co-pay on the day it occurs, unless we agree otherwise or unless you have insurance coverage which requires another arrangement.
You are required to have a *current* credit card on file for <u>all</u> balances over 30 days. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a payment installation plan. If installation plan is not adhered to, your credit card will be charged for the outstanding balance. If your account has not been paid and your credit card cannot be charged, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, those costs will be included in the claim. **In the event that your account goes to collections, there will be a 25% collection fee added to your balance.**
In most collection situations, the only information we release regarding a patients treatment is his/her name, the nature of services provided and the amount due.

NSF FEE: There will be a $30 service charge on all returned checks.

Initial:_____

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be happy to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as a treatment plan or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you and your therapist feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above (unless prohibited by contract).

COURT TESTIMONY AND LEGAL FEES

We do not perform court-related evaluations for child custody nor do we testify in hearings involving child custody issues. In addition, we do not appear voluntarily at any court or

Initial:_____

administrative hearing. If you or your attorney chooses to subpoena a GPCC Therapist or other personnel for court testimony, including depositions or administrative hearings, you will be charged a flat non-refundable fee of $2500 pre-paid two (2) weeks in advance.
In addition, you will be charged $300 per hour for any preparation time GPCC personnel spend getting ready to appear, traveling to and from court, waiting to appear, and/or testifying. These charges will apply even if we are ultimately excused from testifying. By signing this agreement, you agree to pay these charges. Should it become necessary for GPCC to commence collection proceedings or retain an attorney to collect any fees hereunder, you agree to pay any and all attorney's fees and costs incurred by GPCC.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Patients will be charged a Professional fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to require an agreement from parents that they agree to give up access to your records. It is important for minors to have a trusting environment to increase the possibility of therapeutic effectiveness. **By signing the informed consent and by agreeing to undergo treatment it is understood that minors records will be kept confidential, we will provide parents only with general information about our work together, unless we feel there is a high risk that the minor will seriously harm himself/herself or someone else. In this case we will notify the parent/legal guardian of our concerns**

CONFIDENTIALITY

In general, the privacy of all communications between a patient and therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a person's treatment. For example if we believe a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we may be required

Initial:_____

to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalized for him/her or to contact family members or others who can help provide protection.

We may occasionally find it helpful to consult with other professionals about a case. During our consultation, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. We will be happy to discuss these issues with you, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not an attorneys.

ETHICAL OBLIGATIONS

Should you attend your therapy session under the influence of any substance that would impair your ability to safely operate a motor vehicle and upon departure from GPCC, you choose to do so against your therapist's advice; we have an ethical obligation to report this to the local authorities.

Your signature below indicates that you have read the information contained in Gainesville Professional Counseling Center's Outpatient Services Agreement and agree to abide by all of its terms during our professional relationship.

Signature of Patient	Signature of Parent/Legal Guardian
Printed Name of Patient	Printed Name of Parent/Legal Guardian
Date	

GAINESVILLE PROFESSIONAL COUNSELING CENTER

CONSENT

Please read GPCC's Notice of Privacy Policies

Consent to use and disclose your health information

This form is an agreement between you,_____and me/us, Gainesville Professional Counseling Center. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment of for other business or government functions.

By signing this form you are agreeing to let us use your information here. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share information and so may our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 571-261-1921, or in person from our privacy officer.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using and sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his/her representative Date

_____ _____

Printed name of client or personal representative Relationship to client