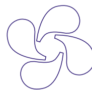


THE COUNSELING OFFICE OF

DEBBIE E. DICKSON COUNSELING, INC.

Website: debbiedickson.com Email: debbie295@msn.com

905A River Road , Granville, OH 43023
PH: 740-587-2822 / 740-294-9006

221 Railroad Street , Warsaw, OH 43844
FAX: 740-824-3776

*** NOTE: Please complete all spaces and if not applicable - designate with an "N/A"**

*** Please attach copies of all insurance cards and EAP coverage authorization**

REQUIRED CLIENT INFORMATION BELOW

INITIAL APPOINTMENT DATE ____________ **ASSIGNED CLINICIAN** ____________

Client Name: ____________ Gender: ☐ Male ☐ Female

Address: ____________ City: ____________ State: _____ Zip: _______

Social Security Number: ____________ Email: ____________

Daytime Phone: ____________ Evening Phone: ____________ Mobile Phone: _______

Date of Birth: ____________ Current Age: ____________

Employer: ____________ Occupation: ____________

Address: ____________ City: ____________ State: _____ Zip: _______

Telephone / Text number for contact: ____________ Email: ____________

GUARANTOR INFORMATION (IF DIFFERENT FROM CLIENT)

Name: ____________ Gender: ☐ Male ☐ Female

Address: ____________ City: ____________ State: _____ Zip: _______

Social Security Number ____________ Email: ____________

Daytime Phone: ____________ Mobile Phone: ____________ Evening Phone: ____________

Date of Birth: ____________ Current Age: ____________

Employer: ____________ Occupation: ____________

Address: ____________ City: ____________ State: _____ Zip: _______

SELF PAY ☐ EAP ☐ Insurance ____________

EAP Company Name ____________ Phone ____________

EAP Authorization Number ____________ # Visit ____________

INSURANCE POLICY INFORMATION

Primary Insurance Company Name ____________ Phone: ____________

Policy Holder Name: ____________ Date of Birth: ________

Policy ID Number: ____________ Group Number ____________

Client's Relationship to Policy Holder: ☐ Self ☐ Spouse / Domestic Partner ☐ Child

Co-Pay Amount: $ ____________ **Pre-Certification Required** ☐ **In Network** ☐ **Deductible Met** ☐ **Unmet** ☐

Secondary Insurance Company Name ____________ Phone: ____________

Policy Holder Name: ____________ Date of Birth: ____________

Policy ID Number: ____________ Group Number ____________

Client's Relationship to Policy Holder: ☐ Self ☐ Spouse / Domestic Partner ☐ Child

Co-Pay Amount: $ ____________ **Pre-Certification Required** ☐ **In Network** ☐ **Deductible Met** ☐ **Unmet** ☐

RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES & OFFICE POLICY

I hereby acknowledge that I have read the notice of the privacy practice and HIPPA Act which can be found on the website of Debbie E. Dickson Counseling, Inc. in the office policy file. Copies are available per request. I understand that these documents provide information on office policy, my rights with respect to my health information, and how my health information may be used or disclosed by Debbie E. Dickson Counseling, Inc.

Signature____ Date:_______________

Relationship to client: self/parent/guardian - legal documentation may be required.

INFORMED CONSENT FOR TREATMENT

I consent to have Debbie E. Dickson Counseling, Inc. and its professional staff perform psychotherapy and/or related mental health treatments when deemed necessary or advisable by appropriate members of the professional staff and/or consultants with Debbie E. Dickson Counseling, Inc. I understand this statement.

Signature____ Date:_______________

Relationship to client: self/parent/guardian - legal documentation may be required.

Witness ____ Date:_______________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I authorize Debbie E. Dickson Counseling, Inc. to release any medical information necessary to process my claims or for quality assurance purposes. I permit a copy of this authorization to be used in place of my original. I authorized this office to apply for benefits on my behalf for covered services rendered and request that payment from my insurance/EAP company be made directly to Debbie E. Dickson Counseling, Inc. I acknowledge that I am responsible for all non-covered services. It is my responsibility to confirm insurance, employee benefits, and copay amounts prior to my initial session. If I have not done so, I will contact my benefit plan immediately to confirm coverage. If coverage is not eligible, I understand that I am responsible for payment of services.

Signature____ Date:_______________

Relationship to client: self/parent/guardian - legal documentation may be required.

CLIENT RESPONSIBILITY

- Provide current demographic information at each session to inform of address/telephone changes
- To keep account activity current and to have adequate arrangements for payment in accordance with Debbie E. Dickson Counseling, Inc.
- Maintain current information concerning the payor source
- To obtain authorizations as needed
- To obtain referrals as needed
- To be accountable for your appointment, treatment and goals set with your counselor
- **If your account goes to collections:** Any and all waived fees may be reinstated, additional fees may apply

DIVORCED PARENTS

It is the policy of this office that the parent accompanying the child for treatments be held responsible for all costs, we cannot bill the other parent.

COMPLETION OF FORMS

There may be a charge for staff to complete disability forms, sick leave and other forms. Please allow 7 to 10 business days to complete. Payment is due at the time of request for service.

CLIENT HISTORY

Present complaint / reason for referral: ______________________________

____

Current medications: ______________________________

____

Medical problems: ______________________________

____

Allergies: ______________________________

____

Past hospitalizations: ______________________________

____

Psychiatric history: ______________________________

____

Signature: ______________________________ Date: ______________

Relationship to client: self/parent/guardian - legal documentation may be required.

CANCELLATIONS / RESCHEDULES

- Please call **24 hours in advance** during business hours to cancel or reschedule - there is a **minimum charge of $75 (seventy-five) for no show/late cancel /late reschedule** (less than 24 hours). Reminder calls are a courtesy only.
- Once you schedule **any appointment**, it is your responsibility to request changes to **each date scheduled** that you need changed - i.e., if you have more than one session scheduled, please advise **for each specific date scheduled**.
- Fees are self-paid fees and payable prior to the next session.
- If three consecutive sessions are no-show or late cancel - you may be referred to another agency.
- **NOTE:** *All notification of appointment changes must be made with the office/clinician directly. Fees may apply if change requests are not made by the client to office administration/clinician directly within 24 hours of your scheduled appointment time.*

Signature____ Date:_______________
Relationship to client: self/parent/guardian - legal documentation may be required.

EMERGENCY / CRISIS CALLS:

- Please call the office at 740-587-2822 or 740-294-9006 or your counselor directly if you have made arrangements with that counselor.
- In case of life-threatening situations, you are advised to contact your local police or Sheriff's department/ Local hospital immediately!
- Routine return call/text/email requests are returned within 24 to 48 business hours. If you have not received a return call during that time, please call again and leave a clear message with your name, who you want to contact, and a clear phone number to contact you.

Signature____ Date:_______________
Relationship to client: self/parent/guardian - legal documentation may be required.

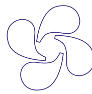
CREDIT CARD AUTHORIZATION (To be completed during first appointment)

I authorized the counseling office of Debbie E. Dickson Counseling, Inc. to charge my credit card to pay for counseling sessions, missed/canceled appointments, deductibles, copays and other services requested of The Counseling Office of Debbie E. Dickson Counseling, Inc.

NAME PRINTED ON CARD: ____
TYPE OF CARD______________________ CREDIT CARD NUMBER ____
EXPIRATION DATE ___________________ CVC 3-DIGIT CODE ON BACK OF CARD_______
CARD BILLING ZIP CODE ____

By signing below, I certify that my above information is true, accurate, and I am an authorized user on the account. I authorize Debbie E. Dickson Counseling, Inc. to keep my credit card information on file and charge any fees that are my responsibility. I give permission to charge my card for any therapy, no-shows/cancellations less than 24 hours, completion of forms, letters and legal requests, and unreturned books.

Signature____ Date:_______________
Relationship to client: self/parent/guardian - legal documentation may be required.



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TELE BEHAVIORAL HEALTH

Tele Behavioral Health is being supported for Mental/Behavioral Health Counseling.

I , ____ (Client), request and am in agreement to receive Tele Behavioral Health services by designated phone/email/contact through virtual contact. (Initial ________)

I do understand that The Counseling Office of Debbie E. Dickson, Inc., follows the guidelines for HIPPA Policy. Clients are asked to affirm that you take measures to choose a private location for optimum privacy. If you would like others to join your sessions, please consult your therapist prior.

I have contacted my insurance / EAP provider.
Name of provider: ____
Phone number of provider: ____
Contact Name: ____

Tele Behavioral Health is authorized. I understand that I may choose to pay for this service out-of-pocket if I so choose.

Authorization Number: ______________________________ **Number of Sessions:** ________________

I believe that the information presented is true to the best of my knowledge and I understand the client responsibility.

Signature ____ Date ______________________________
Relationship to client: self/parent/guardian - legal documentation may be required.

TELE BEHAVIORAL HEALTH INFORMED CONSENT

______ I understand that the Tele Behavioral Health involves the communication of my medical mental health information in the electronic or technology assisted format.

______ I understand that I may opt out of the Tele Behavioral Health visit at any time. This will not change my ability to receive future care at this office.

______ I understand that Tele Behavioral Health may need approval if I am not in the state of my legal residence.

______ I understand that Tele Behavioral Health billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier to include Employee Assistance Programs (EAP), Medicare or Medicaid, and it is my

responsibility to check with my insurance plan to determine coverage.

_______ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of Tele Behavioral Health in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include (but are not limited to):

- Electronic communications being forwarded, intercepted, or even changed without my knowledge, despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my health care provider, that transmission of medical information could be disrupted or distorted by technical failures.

_______ I agree that information changed during my Tele Behavioral Health visit will be maintained by the doctors, other health care providers, and healthcare facilities involved in my care.

_______ I understand that medical information, including medical records, are governed by federal and state laws that apply to Tele Behavioral Health. This includes my right to access my own medical records and copies of medical records.

_______ I understand that Skype, Facetime, or a similar service may not provide a secure HIPPA-compliant platform, but I willingly and knowingly wish to proceed.

_______ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_______ The health care provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_______ I agree that I have verified to my healthcare provider my identity and current location in connection with the Tele Behavioral Health services. I acknowledge that failure to comply with these procedures may terminate the Tele Behavioral Health visit.

_______ I understand that I have a responsibility to verify the identity and credentials of the health care provider rendering my care via Tele Behavioral Health and to confirm that he or she is my health care provider.

_______ I understand that electronic communication cannot be used for emergencies or time sensitive matters.

_______ I understand and agree that a medical evaluation via Tele Behavioral Health may limit my health care provider's ability to fully diagnose a condition or disease. As the client, I agree to accept responsibility for following my health care provider's recommendations including further diagnostic testing such as lab testing, a biopsy, or an in-office visit.

_______ I understand that electronic communication may be used to communicate highly sensitive medical information such as treatment for information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (i.e. alcohol, drug dependence, etc.).

_______ I understand that my health care provider may choose to forward my information to an authorized third party. Therefore, I have informed the health care provider of any information I do not wish to be transmitted through electronic communications.

_______ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a Tele Behavioral Health visit.

_______ I understand that there is never a warranty or guarantee as to a particular result of outcome related to a condition or a diagnosis when medical care is provided.

_______ I agree to waive and release my health care provider in his or her institution or practice from any claims I may have about the televisit, to the extent permitted by law.

_______ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the providers office or to the existing emergency 911 services in my community.

_______ I understand that it is the client's responsibility for this session to be held in a manner or location for the client's privacy. Additional participants may be requested to join the client session with consult from the clinician.

_______ I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

By signing below, I authorize any/all agreed communication with Debbie E. Dickson Counseling, Inc.

Clinician ____

Client/Legal Rep, Relationship to Client ____

Signature ____ Date ______________

Witness to Client Signature ____ Date ______________

I certify that I have explained the nature of this agreement to the client/client's legal representative. I have answered all questions fully, and I believe that the client/legal representative fully understands what has been explained.

Healthcare Provider Signature ____ Date ______________

Original of this form is placed in client's chart. Client may request a copy of this form, check if copy was given to the client _______