New Directions Counseling Center, PLLC
6880 Cobblestone Blvd Suite 1
Southaven, MS 38672

Patient Demographics

*Patient Name:*_____ *DOB:*_____

*Address:*_____ *SSN:*_____

*City:*_____ *State:*_____ *Zip:* _____

*Home#:*_____ *Cell#:*_____ *Work#:*_____

*Email:*_____

*Sex: Male*_____ *Female:* _____ *Marital Status: Single*_____ *Married*_____

Who is responsible for account? (Complete only items that are different from patient)

*Guarantor Name:*_____

*Relationship: Self*_____ *Spouse*_____ *Father*_____ *Mother*_____ *Other*_____

*Address:*_____ *SSN:*_____

*City:*_____ *State:*_____ *Zip:* _____

*Home#:*_____ *Cell#:*_____ *Work#:*_____

Insurance Information:

*Self-Pay:*_____ *Insurance:*_____ *Work Related (EAP)* _____

*Insurance 1)*_____ *Policy#:*_____ *Group #:*_____

*Insured Party:*_____ *DOB:*_____ *SSN:*_____

*Employer:*_____

*Insurance 1)*_____ *Policy#:*_____ *Group #:*_____

*Insured Party:*_____ *DOB:*_____ *SSN:*_____

*Employer:*_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinic/therapist. I understand that I am financially responsible for any balance. I also authorize New Directions Counseling Center, PLLC or insurance company to release any information required to process my claims. I accept full responsibility for any reasonable attorney's fees, court costs, and legal fees associated with the collection of this account if there is a default in payment. I understand that New Directions Counseling Center, PLLC utilizes family billing; therefore the charges associated with any visit may be viewed by other family members. I have been offered a copy of New Directions Counseling Center's Notice of Privacy Practices.

_____ _____

Signature of Client/Legal Guardian ***Date***

NDCC Staff: _____ ***Insurance Card Copied:***_____ ***Photo ID Copied:***_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION.

This private counseling practice has been and will always be **TOTALLY COMMITTED TO MAINTAINING CLIENT'S CONFIDENTIALITY**. *We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes our best policies related to the use and disclosure of your healthcare information.*

Uses and disclosures of your health information for the purposes of providing services:
Providing treatment services, collecting payments and conducing healthcare operations are necessary activities for quality care. State and federal laws allow and sometimes require or mandate us to use and disclose your health information for these purposes.

TREATMENT: *We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.*

PAYMENT: *Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance. We may employ other people to assist us with our billing. If this is done, those individuals are held to the same confidentiality standards and must sign an agreement stating such.*

HEALHCARE OPERATIONS: *We may need to use information to review our treatment procedures and business activity. Information may be used for certification, compliance, and licensing procedures.*

OTHER USES OR DISCLOSURES WHICH DO NOT REQUIRE YOUR CONSENT:
There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by MS STATE LAW, we are obligated to report this to the Department of Children and Family Services; if you provide information that informs us that you are in danger of harming yourself or others; information to remind you of or to reschedule appointments or treatment alternatives; information shared with law enforcement if a crime is committed on our premises or against anyone at this place of business or as required by law such as subpoena or court order; if you make a valid threat of harm, with intent, to someone else.

COMPLAINTS: *If you are concerned that we have violated your privacy rights, or if you disagree with a decision we have made about your records, you may contact Elizabeth Storey. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint. If you have any questions, requests or complaints, please contact Elizabeth Storey.*

I/We have read and understand this Notice of Privacy Practice.

_____ _____

Signature of Client/Legal Guardian ***Date***

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CONSENT TO TREATMENT AND RECIPIENT'S RIGHTS

Client/Patient Name _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under legal guardianship mentioned above with a therapist of New Directions Counseling Center, PLLC. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with the therapist. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that either party may discontinue the therapy at any time; however, we encourage that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Non-Voluntary Discharge from Treatment: *A client may be terminated from New Directions Counseling Center, PLLC involuntarily, if; A) The client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at New Directions Counseling Center, PLLC, and/or B) The client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the involuntary discharge by letter. The client may request to re-apply for services at a later date.*

Client Notice of Confidentiality: *Federal and/or State laws and regulations protect the confidentiality of client records. Generally, we may not say to a person outside of New Directions Counseling Center, PLLC that a client attends New Directions Counseling Center, PLLC or disclose any information identifying a client unless: 1) The client consents in writing, 2) The disclosure is allowed by a court order, 3) The client presents a danger to themselves or others, which includes communicable diseases that can be life-threatening to others, or 4) There is reason to believe that child abuse or neglect is present.*

Federal laws and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is our duty to warn any potential victim when a significant threat has been made. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information.

My signature below indicates that I have been given a copy of my rights regarding confidentiality upon my request.

I consent to treatment and agree to abide by the above stated policies and agreements with New Directions Counseling Center, PLLC.

I certify that I have been given a copy of the HIPPA Privacy Practices and that I understand my rights regarding my Personal Health Information.

_____ _____

Signature of Client/Legal Guardian **Date**

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf

NDCC STAFF: _____

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FINANCIAL POLICY

Operating hours of New Directions Counseling Center, PLLC vary Monday through Friday with evening appointments available. The initial intake assessment is $150.00. Individual, family, and couples therapy is $150.00 for 45 minute sessions. At this time, you will be asked to complete new patient intake forms, provide a photo ID, and your insurance card.

As a service to you, we will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and are not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, the Person Responsible for Payment of Account is responsible for payment of these services. ***We are required by our contracts with the insurance carriers to collect co-pays, co-insurance and deductibles at the time of service****. All insurance benefits will be assigned to New Directions Counseling Center, PLLC (by insurance or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.*

If payment is made with a check and the check is returned to us, the patient is responsible for the amount of the check plus an additional $50.00 returned check fee. This amount must be paid with cash or money order. If the check remains unpaid after the patient has been notified, we will forward the check to the District Attorney's office for collection. Other arrangements can be made with our billing department if needed.

A fee of $50.00 will be charged for each session that you do not show for the appointment or if a 24 hour advanced notice is not given. The $50.00 fee will be directly billed and due by you, not the insurance company. The fee will be due in full before the next visit unless you make other payment arrangements with New Directions Counseling Center, PLLC.

A fee of $50.00 will be charged for each letter the therapist writes to schools, Department of Human Services, employers, doctors, etc. This fee does not pertain to legal matters as there is a separate policy for legal issues, which is covered in this document.

If (2) consecutive appointments are missed, you will be taken off the schedule and required to call in order to schedule more appointments.

Telephone consultations exceeding 10 minutes may be charged at the rate of $50.00

There will be a retainer fee charged that is 72 hours in advance. Please see the fee schedule. The retainer fee will be based on an estimate of the time that will be involved. If the legal matter is not cancelled within 2 business days of the scheduled date, the minimum of $500.00 will be charged. The fee of $150.00 will be charged for all letters or correspondence with attorneys, Youth courts, Guardian Ad Litem, etc.

The client id responsible for any attorney fees/costs of any nature that New Directions Counseling Center, PLLC and/or its therapists incur in regard to any legal matter or court proceedings related to care or treatment of the client.

If this account is litigated or provided to an attorney or a collection agency, the client (or responsible party) agrees to pay all costs of collection, litigation, and reasonable attorney fees.

I authorize New Directions Counseling Center, PLLC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to my third party payer or insurance company for the purpose of receiving payment directly to New Directions Counseling Center, PLLC. I consent that New Directions Counseling Center, PLLC may discuss with or release billing/insurance information with my insurance company. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits.

_____ _____

Signature of Client/Legal Guardian ***Date***

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf

NDCC STAFF: _____

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REGULAR AND CUSTOMARY FEE SCHEDULE

Initial Consultation – by appointment	$ 150.00 Therapy Hour
Individual Therapy	$ 150.00 Therapy Hour
Family Therapy	$ 150.00 Therapy Hour
Group Therapy	$ 75.00 Hour
Reports (Preparations) including insurance reports and evaluations	$ 180.00 Hour
Telephone Consultation	$ 50.00 Ten Minutes
Agency Consultation	Per Contract (Negotiable)
Consultation/Research (Attorney or Court Related)	$ 180.00 Hour
Custody/Family Evaluations	$ 180.00 Hour
Courtroom Testimony	$ 2000.00
Appointments cancelled within less than 24 hours	$ 50.00

All fees are due and payable at the time services are rendered. Methods of payment include personal check and cash. The cost for custody and/or family evaluations may be split by the parties involved but must be paid by the parties involved at the time of, or prior to the evaluation. Insurance claims can be filed individually or by this office. However, the initial consultation must be paid in full. Any insurance reimbursements will be credited to your account. Fees not covered by insurance are not due at the time of service. All fees are subject to change without further notice.

_____ _____

Signature of Client/Legal Guardian ***Date***

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf

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Coordination of Care between Healthcare Providers and Release of Information

I want to inform you that _____ was seen by me for the treatment of:
(Member name)

DSM-IV and or medical diagnosis: _____

Date of appointment: _____

Summary: _____

_____

_____

_____

_____

The treatment plan consists of the following modalities:

____ Individual Psychotherapy ____ Group Psychotherapy ____ Medication Management (See Below)

____ Psychological Testing ____ Family Psychotherapy _____Other (Specify)

Current Medication(s) (Dosage and Delivery):

_____

_____

_____

_____

The following medication was or will be started (indicate medication and dosage):

_____

_____

Estimated length of treatment: _____

_____

(Print Provider Name) **(Signature)** **(Date)**

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and State law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients

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Coordination of Care between Healthcare Providers and Release of Information

Communication between behavioral health care providers and your primary care physician (PCP), other behavioral health providers and/ or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. The PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) at any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, you benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbal or written information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires six (6) months from the date of my signature below unless otherwise stated herein.**

_____ is authorized to release protected health information related to the evaluation and
(Current Provider Name – Please Print)

treatment of _____ _____ _____.
(Member Name) **(Member ID#)** **(Date of Birth – MM/DD/YYYY)**

PCP Name: _____ PCP Phone: _____

PCP Address: _____ _____
(Street) **(City)** **(State)** **(Zip Code)**

Other BH Provider Name: _____ BH Provider Phone: _____

BH Provider Address: _____ _____
(Street) **(City)** **(State)** **(Zip Code)**

Other Name: _____ Other Phone: _____

Other Address: _____ _____
(Street) **(City)** **(State)** **(Zip Code)**

Disclosure may include the following verbal or written information: (Check all that apply)

___ Face Sheet
___ History & Physical
___ Laboratory/Diagnostic Testing Results
___ School Information
___ Discharge Summary
___ Medication Records
___ Behavioral Health/Psychological Consult
___ Psychological Testing
___ ER Record Report
___ Psychiatric Evaluation
___ Psychological Assessment
___ Other
___ Substance Abuse Treatment Record
___ Summary of Treatment Records & Contact Dates

___ I hereby refuse to give authorization for any release of information

_____

(Signature of Patient, Parent, Guardian or Authorized Representative) **(Date)**

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

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MISSED APPOINTMENT FEE AUTHORIZATION FORM

In order to be respectful of the needs of other patients, please be courteous and call our office if you are unable to keep a scheduled appointment. This will allow us to reallocate your appointment time to another patient in need of care. Please provide us with a minimum of 24 hours' notice if you need to cancel your appointment. To cancel or reschedule an appointment, please call our office at (662) 253-8324. Regretfully, excessive and chronic missed appointments have necessitated the implementation of a missed appointment fee. We understand that true emergencies do occur and will be mindful and considerate of those rare times.

Occasionally, we are busy and unable to answer your call, which leads to you being connected to our voicemail. If you are trying to cancel by phone and reach our voicemail box, please leave your full name, phone number, and time of your appointment in order to cancel. Please note, if you do reach our voicemail box and choose not to leave a message, failing to notify us, this will also result in the missed appointment fee.

- ☐ I accept this policy and will sign the credit card authorization form.
- ☐ I accept this policy and decline to sign the credit card authorization form but will leave the required $50.00 missed appointment deposit fee.

The below signatures acknowledge that the patient has provided a $50.00 cash credit to be available in the event of a missed appointment. Notification will be sent when then credit is applied for the patient's missed appointment. If a patient chooses to discontinue therapy at New Directions Counseling Center, PLLC and this credit remains on the patient's account, a check to reimburse the patient will be mailed within 30 days.

Patient Name: _____ Date: _____

Patient Signature: _____

Credit/Debit Card Authorization Fee

I understand that a $50.00 fee will be applied to my credit/debit card if I miss an appointment (no-show or cancel without a 24 hour advance notice.

Name on Card: _____

Type of Card: VISA MASTERCARD DISCOVER AMEX DEBIT

Card Number: _____

Card Expiration Date: _____

Security Code/ CVV (3 digit code on back of card): _____

For patients who do not use credit/debit cards or do not wish to keep a card on file, a $50.00 cash credit is required for our missed appointment policy.

_____ _____

Signature of Patient/Legal Guardian **Date**

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf

NDCC STAFF: _____

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UPDATED MISSED APPOINTMENT POLICY

IMPORTANT NOTICE FOR ALL PATIENTS

As of March 1, 2016, New Directions Counseling Center, PLLC (NDCC) is implementing an updated missed appointment policy. Regretfully, this policy is necessary due to excessive and/or chronic no-show appointments or late cancellations.

NDCC's policy requires a **24 hour notice** for all appointment cancellations to allow the clinician maximum availability for their patients. **When visits are missed or cancelled with less than 24 hours, other patients who need this service and time are denied the opportunity to be seen.**

A notification will be sent to the patient, along with a notice of the cancellation fee of $50.00 that has been applied to the patient's credit/debit card on file. A signed form by the patient recognizing and authorizing this fee will be kept in the patient's file. If a credit/debit card is not on file, the clinic will apply the $50.00 cash credit that has been paid by the patient. The patient may also be dismissed from the practice due to excessively missed appointments. This will be determined on a case-by-case basis with variables such as history of a patient's attendance and extenuating circumstances for missed appointments. A referral will be made if dismissal is deemed warranted.

APPEAL POLICY

Patients have the right to appeal the missed appointment fee by contacting our office manager, Kenney Storey at (662) 253-8324. The patient's counselor and office manager will appeal requests. Appeal decisions will be sent in writing to the patient.

_____ _____

Signature of Patient/Legal Guardian **Date**
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf

NDCC STAFF: _____