

Life Christian Counseling LLC

Today's Date: _____

Client: _____ Age: _____ DOB: _____

Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Primary Contact #: () _____ EMAIL(for appt. reminders) _____

Home #: () _____ Cell #: () _____ Work #: () _____

Social Security Number (MUST HAVE): _____ Referred By: _____

Check Appropriate: Gender: ___F ___M ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

If minor, parent(s)/guardian name: _____

Person Responsible for Account:

Name: _____

Relationship to Client: Self ___ Spouse ___ Child ___ Other _____

Address of Responsible Party:

Street: _____ City: _____ St: _____ Zip: _____

DOB: _____ Social Security(MUST HAVE) _____ Phone: _____

Place of Employment: _____ Phone: _____

Emergency Contact Name, Phone Number, Relationship: _____

1.Primary Insurance Company: _____ Phone #: _____

Insured's Name: _____ DOB: _____

Social Security of Insured (MUST HAVE): _____ Gender: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: () _____ Cell: () _____ Work: () _____

Employer: _____

ID Number: _____ Group Number: _____

2.Secondary Insurance Company: _____ Phone #: _____

Insured's Name: _____

Social Security of Insured (MUST HAVE): _____ Gender: _____

Address: _____ City: _____ St: _____ Zip: _____

Employer: _____

Phone: () _____ Cell: () _____ Work: () _____

FINANCIAL ASSIGNMENT AND RELEASE

I agree to pay Life Christian Counseling, LLC and its consultants for all counseling services rendered. If counseling services are covered by private insurance, benefits due to me under existing policies are hereby assigned to Life Christian Counseling, LLC. I permit a copy of the signature on this release to serve as a lifetime authorization. A copy of this form may be used in place of the original. I understand that specific diagnostic and treatment information may be required by third party payers and I consent to release all requested information. I understand that I am personally responsible for the costs of counseling services including but not limited to:

1. Unmet deductibles, co-insurance, and co-pays.
2. Any fees or unpaid portions not covered by insurances.
3. All broken appointments without 24 hour notice (emergencies do not apply): A broken appointment fee without 24 hour notice is \$100.00.
4. All payments are expected at the time of service. Failure to maintain account balance will result in legal action. Any additional expenses incurred by legal action will be added to your balance and will also be your responsibility.
5. All past due balances will result in interest charges in the amount of 18% annually (1.5% per month).

I hereby consent to treatment and affirm that I have read this financial agreement and release. I agree to abide by these terms in full.

Client/Name: _____ Date: _____
PRINT NAME

Client/Responsible Party: _____ Date: _____
SIGNATURE

Witnessed by: _____ Date: _____
SIGNATURE

Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health of condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *ACA Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at the time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processed due to lack of payment for services we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without and

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authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a licensed professional counselor in this state and a member of the American Counseling Association, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addressed these categories to the extent consistent with the *ACA Code of Ethics* and HIPAA.

Child Abuse and Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose information to close family members or friends directly involved in your treatment based on your consent or necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from the U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety

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of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (a) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (b) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (c) disclosures that constitute a sale of PHI; and (d) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 843-771-5433

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12 month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying our payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

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- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 117 E. Main St., Moncks Corner, SC 29461, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is January 2015.

Life Christian Counseling LLC

**Notice of Privacy Practices
Receipt and Acknowledgement of Notice**

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Life Christian Counseling LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Vicky Stahl, LPC.

Signature of Patient/Client

Date

Signature of Parent, Guardian or Personal representative*

Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt

Signature of Staff Member

Date

Life Christian Counseling LLC

Client Name: _____

DOB: _____

Policies and information for all Clients:

Welcome to Life CC! Insurance reimbursement rates rarely cover the full cost of your treatment here at Life CC. In order for us to continue accepting insurance we must closely follow the policies outlined below.

PLEASE INITIAL NEXT TO EACH STATEMENT

1. Most insurances charge you a deductible at the first of every year. Most of the time Behavioral Health/Counseling is SEPARATE deductible from your routine medical deductions. We ask that you check your policy(s) for this as every policy is different. As a courtesy, we will file most insurance claims for you. If you have a deductible, you will be charged the insurance company's allowable charge per service IF we have a contract with your company until your deductible has been met. _____
2. We expect our clients to be FULLY responsible for their deductibles, co-insurances, and co-pays. Please feel free to request a copy of your account and balances. _____
3. We expect payment at time of service. We accept cash, checks, VISA and MASTERCARD. _____
4. Returned check fees are \$35.00 per returned check and are payable by cash or credit card only. _____
5. We require 24hour notice for cancellation of appointments (emergencies do not apply). We cannot charge insurances for broken appointments so you will be held responsible for these fees. We reserve the right to close your case for broken appointments and unpaid fees. Medicaid clients may be terminated after one broken appointment. Any client may be terminated for failure to follow our treatment recommendations. _____
6. Counseling sessions are 45-60 minutes. Any run over time will be charged as a second session. Note: Your insurance may not cover for extended sessions. If any charges accrue due to this, these charges will be your responsibility. The fee will be the allowable charge of your insurance policy. _____
7. We do not do phone sessions. However, if you need to speak to your counselor, you may leave a message and she will call you back as soon as possible. We recommend that you wait until your next appointment to discuss general issues with your counselor (if possible) due to the time constraints and counselor availability. _____
8. We do our best to collect payment from your insurance company. However, there may be times when issues arise with your insurance and they will not pay your claims. We will make an effort to resolve this but if we are unable to do so your will be notified and balances will be forwarded to your account and you will be held responsible for the payment. _____
9. We try to serve our clients with Love and consideration. We make every effort to return your calls and provide the best care for you. Our phone is available for you to leave a secure message. Any cancellation left on our phone or emailed after hours are not considered 24 hour notice. You must cancel before the close of each business day (5pm). We request that you contact us during business hours (9am to 5pm, Monday - Friday) to reschedule appointments. _____

If for some reason you cannot agree with the policies described above, we will gladly refer you to another provider.

I have read and agree to the policies and procedures of Life Christian Counseling LLC outlined above.

Client Name _____

Date _____

Responsible Signature _____

Date _____

Witness _____

Date _____

