Client Intake Information / Notice of Privacy Practices /Financial Responsibility

Today's Date:______________________

Client First Name:_________________________ MI:_________ Last Name:_____________________________

Client Date of Birth:__________________________

Client Driver's License#: ________________State Issued: __________

Client Address:________________________________City:____________________State:___Zip code:_________

Gender:__________Ethnicity(Optional):_________Marital Status: _______

Home Phone:_______________________Cell:_______________________Work:___________________

Ok to leave message? _____Y _____N Email Address:_______________________________________

Preferred Contact Method: ___Electronic Text Message ___Email Message ____Telephone Message

_____Check if client is a minor ***Note: If minor, please provide copies of Court/Custody Papers**

Legal Guardian (skip if not applicable): Custody_____Mother _____Father _____ Joint _____Other

Legal Guardian's Name:_______________________________________

Mother's Name (if minor):__________________________Father's Name (if minor):_________________________

Military Experience?
Present or Past Experience Serving in the Military? □ Yes □ No If yes – which branch?__________________

Client Employer / School:
Employer____ FT____ PT____ Other______

Last School Attended (if Minor):_______________________________________Current Grade (if Minor):_____

Are you being referred? ___Y ___N How did you hear about us?:____________________________________

Emergency Contact List / Family Members involved in Client's Treatment

Emergency Contact Name:______________________________Emergency Contact Phone #________________
Relationship:______________

Emergency Contact Address:___________________________City:_____________State:_____ Zip code:_______

Insurance Policy Holder / Financially Responsible Person Information
[Please Bring Your Insurance Card and Co-pay Fees to Your Appointment]

First Name:________________________________ MI:_________ Last Name:_____________________________

Date of Birth:___________________________ Social Security #:____

Address:____City:____

State:____________________Zip code:______________________ Phone #:_______________________________

Email:____Policy Holder's Employer:___________________________

Insurance Policy Holder Driver's License #:____________________Primary Insurance Plan Name:_____________

Insurance ID #:____Insurance Group Policy#:________________

Amount of Co-pay $:_____________ Insurance Customer Service #:_____________________________________

Secondary Insurance Plan **(skip to next session if not applicable)**: ___Y ____N ____NA

Secondary Insurance Plan Name:____

Insurance ID #:____Group Policy#:_______________________

Amount of Co-pay $:____________ Insurance Customer Service #:__________________________________

I understand that I am financially responsible for all deductibles, co-pays and missed appointments, or appointments cancelled without 24-hour notice. I confirm that information I provided is accurate and complete, to the best of my knowledge.

I understand that if I do not inform Magnolia Counseling Solutions, LLC of changes in my insurance coverage before services are rendered, I will be financially responsible for payment in full. I am also responsible for informing Magnolia Counseling Solutions, LLC of any changes in my address, phone number, and emergency contact information.

I UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW THERAPIST IF I FAIL TO SHOW UP FOR THREE CONSECUTIVE APPOINTMENTS, WITHOUT PROVIDING A 24 HOUR NOTICE. WE WILL NOT CONTINUE TO PROVIDE SERVICE AFTER THREE NO-SHOWS. I HAVE READ AND AGREE TO THE ABOVE POLICY TERMS.

X (Signature of Responsible Party) Date

Assignment of Benefits

I hereby assign, transfer and set over to Magnolia all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize Magnolia to file (and assign to Magnolia my right to file) my insurance claim under my policy for Magnolia's services. I further authorize the release of any medical information needed to determine benefits, including psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

MUST BE SIGNED IF INSURANCE IS TO BE USED TO REIMBURSE "MAGNOLIA"

X (Signature of Responsible Party) Date

Notice of Privacy Practices Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of

Magnolia Counseling Solutions, LLC Notice of Privacy Practices.

I understand that I may request a hardcopy of Magnolia Counseling Solutions, LLC Notice of Privacy Practices or access an electronic copy via Magnolia Counseling Solutions Website: **www.MagnoliaCounselingSolutions.com/forms**

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Magnolia Counseling's Officer at **Magnolia Counseling Solutions, LLC at 1565 Ebenezer Rd, Suite #135, Rock Hill, SC 29732** (803) 384-7333.

X (Client / Parent / Guardian Signature or Personal Representative) Date

Magnolia Counseling Solutions, LLC FINANCIAL POLICY

First Appointment: Please arrive for your initial appointment with all paperwork completed or 10 minutes early for any additional infomation needed. Please bring your current insurance card with you EACH VISIT. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up-to-date. Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-pays, deductibles or any non-covered services will be required at the time of service. Paying applicable co-pays/deductibles/co-insurance charges at the time of service does not mean that you will not receive a bill after your visit, fees are only estimated. For your convenience, we accept CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT.

Insurance: When scheduling an appointment at our practice, it is your responsibility to confirm with your insurance company that the clinician is under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral in hand at the time of your appointment. If your insurance should happen to change, we require that you notify our office 24 hours prior to your appointment time. If you do not notify us (before the date services are rendered) of any changes in your insurance coverage, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

PROOF OF INSURANCE. PATIENT MUST PROVIDE CORRECT INSURANCE INFORMATION AT TIME OF SERVICE. FAILURE TO DO SO MAY RESULT IN A $20 REBILLING CHARGE.

CO-PAYS: CO-PAYS ARE DUE AT THE TIME OF SERVICE. A $20 BILLING CHARGE MAY BE ADDED TO COVER BILLING EXPENSES IF NOT PAID AT THE TIME OF SERVICE.

Client is responsible for knowing their benefit coverage for specialist visits. We will be happy to file your insurance claim on your behalf. We allow 45 days from date the claim was filed for your insurance company to pay. If your insurance does **NOT** pay within this time, you may be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and / or policy benefit criteria (e.g., deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary charges, etc.) other than to supply factual information when necessary.

Out-of-Network Insurance & Insurance Denials: If you have insurance that our practice does not accept or claim is denied by your insurance company, you will be responsible for the full amount of all professional fees and charges for services provided. We can provide you with a receipt for clinical services rendered that you may submit to your insurance company for reimbursement.

If you are insured by a managed care organization (HMO), and are being seen for any covered service, you must have PRIOR AUTHORIZATION**.** If you do not obtain authorization, you will be responsible for PAYMENT IN FULL. We suggest that you contact the customer service number on your insurance card prior to your first visit to determine if prior authorization is required as well as basic information regarding your behavioral health benefits.

Any Preferred Provider (PPO) or In-Network discounts will not apply UNLESS YOU HAVE YOUR INSURANCE CARD WITH YOU**.** If you do not have your insurance card with you, insurance has instructed us to collect payment in full for all services received. In the event your insurance carrier informs us your eligibility status has changed, you will be responsible for payment in full until verification of insurance benefits is obtained from your insurance carrier.

Usual and Customary Rates: Magnolia is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

You are responsible for deductibles, co-insurance, non-covered services, and any other charges your insurance may not cover. You will be sent monthly statements regarding any monies owed by you, the client. If the same balance becomes more than 3 months past due, you will be charged a finance charge of $20.00 each month thereafter until the balance is paid in full. If your account should ever have to be turned over to a collection agency, all discounts will be removed and collection processing fees will be added to the account. Additional fees may be added if the account is not paid within 45 days of being placed in collections. Credit bureaus are advised of unpaid debt.

Collections: Accounts will be sent to collections after 90 days if not paid as agreed. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim].

Missed Appointments and Late Cancellations: Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place, and have no way of recovering lost revenue due to "no-shows" or last-minute cancellations.

Magnolia charges a *$45 administrative fee for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice (*Note: excludes the following: Aetna EAP, Corp Care EAP, Business Health Services EAP, Managed Health Network HMO / EAP / TriCare North, ComPsych EAP, Deer Oaks EAP, SC Medicaid clients or in the case of emergency situations). This fee is non-refundable and is **not** covered by your insurance or EAP.

Administrative Fees: Similar to other medical practices, declining insurance reimbursements and rising costs force us to charge for certain administrative services that are not covered by insurance. The following fees are applicable to all patients and are **not covered by insurance or EAPs** in which patient shall be solely responsible:

- **Review of Psychological / Medical forms / Disability Claims, Legal Forms, Court Documents, Reports, & Letter Completion (completed outside of appointment times): $50 minimum [pro-rated at $25 / 15 minutes to complete thereafter]**
- **Non-Crisis Telephone Consult / After-Hours Consult with Clinician - $30 minimum [pro-rated at $25 / 15 minutes thereafter]**
- **E-mail Consult with Clinician - $50 minimum [pro-rated at $25 / 15 minutes to complete thereafter]**
- **Court Appearance / Court Testimony - $175 / hour *Note: this fee will apply for each hour clinician is required to be present and not specific to time spent providing testimony**

Thank you for understanding the reason behind these fees. We will be reasonable in applying them and notify you when they apply.

X (Signature of Responsible Party) Date

Consent for E-Mail and Electronic Means of Communication

As a covered entity under the HIPAA Privacy and Security Rules, we take your privacy and right for confidentiality seriously. Although it is convenient, email and other forms of electronic communication is not a secure medium because third parties can view and store confidential information. Therefore, email and other forms of electronic communication are *not* to be considered completely confidential forms of communication, and using email runs the risk of breaching your confidentiality.

RISKS OF USING E-MAIL & OTHER FORMS OF ELECTRONIC COMMUNICATION TO COMMUNICATE WITH MAGNOLIA COUNSELING Transmitting client information by e-mail has a number of risks that clients need to consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail senders can easily type in the wrong email address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies or e-mail may exist even after sender or recipient has deleted his or her copy.
- Employers and on-line services have a right to archive & inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-Mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

TYPES OF PERMISSIBLE E-MAIL OR ELECTRONIC COMMUNICATION THAT CLIENT AGREES TO SEND AND/OR RECEIVE the types of information that can be communicated via e-mail with Magnolia Counseling includes (please check which items you consent to):

☐ Appointment scheduling requests and appointment reminders
☐ Billing and insurance questions and patient education
☐ Use of e-mail for general client information only.
☐ **I agree not to use e-mail for clinical or psychiatric emergencies, other time sensitive matters, or for non-general clinical information**.

If you feel that you have a **life-threatening emergency, call 911 or go to the nearest emergency room**. In addition, contact the **National Suicide Prevention Hotline # 1-800-273-8255 or 1-800-784 2433** to be connected to a skilled, trained counselor at a crisis center 24/7.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT I acknowledge that Magnolia's therapists and practice administrative staff will not accept friend or contact requests from current or former client's social networking site (e.g., Facebook, LinkedIn, etc.). I understand that adding current or former counselors or practice administrative staff as friends or contacts can compromise my confidentiality and respective privacy.

I have had the opportunity to discuss the above and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the therapist and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the therapist may impose to communicate with patients by e-mail. Any questions I may have had were answered.

X (Client / Parent / Guardian Signature) Date

Magnolia Counseling Solutions, LLC

Name:______________________Age:_____Gender:________ Today's Date:_____________

Date of Birth:_______________Current Height:___________Current Weight____________

CLIENT HEALTH QUESTIONNAIRE The following questionnaire is an important part of providing you with the best care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

1). Current symptoms:

0 = None
1 = Mild (impacts quality of life but no significant impairment of day-to-day functioning)
2 = Moderate (significant impact on quality of life and/or day-to-day functioning)
3 = Severe (great impact on quality of life and day-to-day functioning)

Symptom	Rating
Problems with attention / concentration / thinking	0 1 2 3
Problems with memory	0 1 2 3
Racing thoughts	0 1 2 3
Mood swings	0 1 2 3
Mania / Hypomania	0 1 2 3
Problems with sleep	0 1 2 3
Nightmares / bad dreams	0 1 2 3
Depressed, feeling down or low mood	0 1 2 3
Anxiety / excessive worry	0 1 2 3
Panic attacks	0 1 2 3
Grief / loss	0 1 2 3
Feeling overwhelmed	0 1 2 3
Concern for your safety or well-being	0 1 2 3
Thoughts of self-harm	0 1 2 3
Alcohol intake	0 1 2 3
Substance abuse	0 1 2 3
Irritability (anger)	0 1 2 3
Phobias (excessive fears of certain things)	0 1 2 3
Repeating unwanted thoughts or behaviors	0 1 2 3
Suspiciousness of others	0 1 2 3
Hearing things without apparent cause	0 1 2 3
Seeing things without apparent cause	0 1 2 3
Aggressive behaviors	0 1 2 3
Thoughts of hurting others	0 1 2 3
Problems with impulse control	0 1 2 3
Not complying with rules or laws	0 1 2 3
Sexual problems	0 1 2 3
Problems with appetite	0 1 2 3

2). What would you like to accomplish with your time in therapy?