Still Waters Counseling

INITIAL CONTACT INFORMATION SHEET – CHILD

Name: _____ DOB: _____ Date of Contact: _____

Parent Names: _____

Grade Level / School: _____

Home Address: _____

Phone numbers / Leave message? : _____

Method for Reminder Messages: ☐ Phone: _____ ☐ E-mail: _____

Emergency Contact: Name of person_____ Phone #:_____

Insurance Company: _____ Policy #: _____

Subscriber Name / DOB: _____ Group #:_____

Subscriber's Employer: _____

Referral Source / Phone: _____

Brief Description of the Problem: _____

_____

_____

Type of Service Requested: ☐ Counseling ☐ Psychological Testing ☐ Other
☐ Comprehensive Assessment Discussed

Previous Treatment and Providers: _____

Persons in Household (names, ages, gender): _____

_____

If Parents Divorced, Location of Other Parent: _____ Legal Custody? ☐ Yes ☐ No

Available for Daytime Appt? ☐ Yes ☐ No Office Location Requested: _____

AutoPay Information

Name on Card: _____ Card #: _____

Exp. Date: _____ CVV Code: _____

Still Waters
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Billing Information Form

Client Name: _____
Client DOB: _____
Relationship to insured: _____
Marital Status: _____
Vocational Status: _____
Condition Related to: ☐ Employment? ☐ Auto Accident? ☐ Other Accident?
If yes, explain: _____
Insured's Name: _____
Insured's DOB: _____
Insured's Address: _____
Insured's Phone #: _____
Insured's Employer: _____
Name of Insurance Company: _____
Policy Number: _____
Group Number or FECA Number: _____
Insurance Company Phone: _____
Billing Address: _____

_____
Coverage (deductible, copayment, number of sessions per year, etc):

_____

_____
Is there another Health Plan? ☐ Yes ☐ No
If yes, which plan is primary? _____

Secondary Insured's Name: _____
DOB: _____
Address: _____
Phone #: _____
Employer: _____
Name of Insurance Company: _____
Policy Number: _____
Group Number or FECA Number: _____
Insurance Company Phone: _____
Billing Address: _____

_____
Coverage (deductible, copayment, number of sessions per year, etc):

_____

_____
Notes:

Still Waters
Counseling

Still Waters is seeking to improve the scope and quality of our services, by developing programs and materials to support ongoing individual or family therapy.

If you would like to receive information about these programs and materials from us, please indicate your preferred method of communication below:

1. By e-mail
   E-mail address _____

2. By U.S. Mail
   Mailing address _____

   _____

3. Other (specify): _____

4. None of the above

Your Name: _____

Signature: _____

Today's Date: _____

Still Waters
Counseling

Consent for Treatment

I agree to receive psychological services at Still Waters Counseling. These services may include individual counseling, family counseling, relationship counseling, group counseling, and psychological testing. I understand that if Still Waters Counseling does not provide a service which is requested or necessary, I will be referred to an appropriate provider of that service.

I understand that all information that I share with my counselor will be kept confidential and will not be released without my written consent. I understand that the professionals of Still Waters Counseling regularly consult with one another in order to provide me with the highest quality care possible, and may share information about my case for purposes of consultation. Information may also be shared with my insurance company to the extent necessary to secure payment for services.

I understand that confidentiality is not absolute, that in some circumstances my counselor or psychiatrist may be required by law or by the ethical standards of the American Counseling Association the American Psychological Association to share information about my case. Information may be released without my consent in situations where there is reason to believe that I might harm myself or others, or in the case of actual or suspected child abuse or neglect.

I understand that although participation in mental health services will likely result in significant benefit, there are also risks involved. I understand that talking about personal issues in counseling may be upsetting, and in the short term may increase my level of discomfort. However, despite these risks, I understand that the process of mental health treatment is often helpful in making positive changes in my life and my relationships with others.

I hereby certify that I have read and fully understand the above authorization and agree to participate in services at Still Waters Counseling. I further understand that I can withdraw from services at any time.

_____

Client Name (please print)

_____ _____

Client / Parent / Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical, mental health and substance abuse information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Still Waters Counseling is committed to protecting the privacy of your medical, mental health and substance abuse information. We create a record of the care and services that you receive from us. This information is needed to provide you with quality care and to comply with certain legal requirements. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices. We are also required to comply with the terms of this notice.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care options and for other purposes that are permitted or required by law. This notice also describes your rights regarding the information that we maintain about you and a brief description of how you may exercise those rights.

"Protected Health Information" means medical, mental health and substance abuse information, including identifying information about you that we have collected from you or received from others.

The privacy practices in this notice apply to all Still Waters Counseling staff, contract workers, students and volunteers.

Your Rights: You have the following rights regarding your protected health information.

- **Confidential Communications** You may ask that we communicate with you in a particular way, or at a certain location, such as calling you at work rather than at home, to maintain your confidentiality.
- **Inspect and Copy** You have the right to review and/or receive a copy of the information in your record. Under certain limited circumstances, we may have to deny your request. If we deny your request, you may ask for a review by contacting the Still Waters Counseling Office Manager.
- **Addendum** You may ask us to add an addendum to the information in your records if you feel that the information is incorrect or incomplete. Your request may be denied if we did not create the information. You may prepare a statement that will be included in our clinical record if you do not agree with information in your record.
- **Accounting of Disclosures** You may request a list of disclosures that we have made of your protected health information with the exception of treatment, payment and healthcare operations described in this notice, or information that was released with your authorization.
- **Requesting Restrictions** You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we do, we will honor your request unless the information is needed to provide emergency treatment for you.
- **Receiving a Copy of this Notice** You may receive a paper copy of this notice at any time upon request.

How We Will Use and Disclose Your Protected Health Information

Uses and Disclosures that may be Made for Treatment, Payment, and Healthcare Operations

- **For Treatment** We may use and disclose your protected health information to provide, coordinate, and manage your care and services. Information about you may be shared with Still Waters Counseling staff, contract workers, students, or volunteers who are involved in your care or services. This information will be shared on a "need to know" basis.

  We also may use your health information in order to remind you about an appointment at Still Waters Counseling or to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

  Business Associates: There may be some services provided through contracts with "business associates." We may need to share information about you with our "business associate" in order to coordinate and manage your services. To protect the privacy of your health information, "business associates" are required to abide by all aspects of this Notice of Privacy Practices.

- **For Payment** Your protected health information will be used and disclosed, as needed, to obtain payment for your services. For example, a bill for services sent to you or to a third-party payer such as a Medicaid HMO, might include identifying information about you such as your name, your diagnosis and services received.
- **For Health Care Operations** We will use or disclose, as needed, your protected health information to support and improve the activities of Still Waters Counseling. For example, Still Waters Counseling staff may use information in your clinical record to evaluate the care that you received. This information would then be used in efforts to improve the quality and effectiveness of services provided by Still Waters Counseling.

Uses and Disclosures That May Be Made Only With Your Specific Authorization

- Other uses and disclosures of your protected health information will be made only with your specific written authorization, unless otherwise permitted or required by law as described below. For example, your written authorization would be required for us to share your confidential information with a member of your family or with your family doctor except in circumstances specified in this notice. You may revoke this authorization at any time, in writing, except to the extent that we have already taken an action to use or disclose your information, relying upon our authorization.

Uses and Disclosures That May Be Made Without Your Authorization

- **As Required by Law** We may be required by federal, state, or local law to disclose your protected health information. For example, if you have threatened to harm another person, we may be required to notify the local police department and the threatened person.
- **For Public Health Activities** We may need to disclose your protected health information to a public health authority that is required by law to receive the information. Such disclosures would be made for the purpose of controlling disease, injury, or disability. For example, a disclosure regarding HIV/AIDS status would be made to the local Department of Public Health if necessary to protect the health of an individual, diagnose and care for the mental health consumer or to prevent further transmission of the virus.
- **Abuse or Neglect** We may be required to disclose your protected health information if we suspect that you or another person has been abused or neglected.

- **Health Oversight** We may be required to disclose your protected health information for an audit, inspection, investigation or other health care oversight activity.
- **Judicial and Administrative Proceedings** We may have to disclose your protected health information if we receive a court order or subpoena or for risk management purposes.
- **Law Enforcement** We may have to disclose your protected health information in connection with a criminal investigation by a federal, state, or local law enforcement agency, or to authorized federal officials who provide protective services for the President or other persons.
- **Serious Threat to Health of Safety** We may be required to disclose information about you when it is necessary to prevent a serious threat to your health and safety or that of another person or of the public.
- **Coroner or Medical Examiner** We may need to disclose your protected health information to help identify a deceased person or to determine a cause of death.
- **Research** We may disclose your protected health information to researchers if their research proposal includes protocols to insure the privacy of your health information and has been approved by the appropriate research review board.

If you believe that your rights have been violated, contact the Still Waters Counseling Director or the Office of Civil Rights. Your services will not be affected in any way if you file a complaint.

To file a complaint with Still Waters Counseling or if you have any questions or want more information, call or write:

Director
Still Waters Counseling
137 Keveling Dr.
Saline, MI 48176
734-944-3446

To file a complaint with the Office of Civil Rights, call or write:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201
1-877-696-6775 (toll free)

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____(client name), acknowledge that I have received a copy of Still Waters Counseling's Notice of Privacy Practices.

My signature below indicates that I have received the notice and that I have been provided an opportunity at ask questions about the agency's privacy practices as they pertain to my protected health information.

_____

Signature Date

Still Waters Counseling

FEE AGREEMENT

Initial Assessment	$195.00
Individual/Family Counseling	$165.00 (60 min); $110.00 (45 min); $85.00 (30 min)
Crisis Intervention Contact	$165.00 / hour; $85.00 (each additional 30 min)
Group Therapy	$ 45.00 / hour
Psychological Testing	$150.00 / hour (including interpretation & write-up time)
Biofeedback Session	$165.00 (60 min); $100.00 (30 min)
Court Appearance	$300.00 / hour (including travel and preparation time)
Completion of Paperwork for Outside Entities (e.g., disability forms) - $50.00 per hour	

Clients are responsible for payment of all fees. We will be happy to submit a claim to your insurance company or provide you with a receipt for submitting your insurance claim. However, clients are ultimately responsible for payment of their bill.

Fees are payable at the time of service. A $75 broken appointment fee will be charged for counseling appointments canceled without a 24 hour notice or if an appointment is missed without notice. For Monday appointments, 24 hour notice means calling prior to your appointment time the Friday prior to your appointment.

For psychological testing sessions the broken appointment fee is $195 and cancelling/rescheduling requires 72 hour notice due to the large block of time that has been reserved.

There will be a $20.00 fee for each check returned for insufficient funds or other reasons, plus any fees charged to us by our bank.

If payment becomes problematic for you, we are willing to develop an individualized payment agreement with you. However, if you fail to communicate with us about your bill or do not follow through on the payment plan, we reserve the right to turn your account in to collections. Your signature below gives us the right to report any unpaid amounts to a credit reporting agency, to obtain a copy of your credit report to help us or our agent to collect any amounts not paid by you. You also agree that you may be held liable for attorney fees, court costs, collection fees or other costs involved in collecting any unpaid amounts.

I have read and agree to the terms of the above fee policy.

_____ _____

Client / Parent / Legal Guardian Name / Date (please print) Client / Parent / Legal Guardian Signature

The form of payment I prefer to use is: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Savings Account

I would like to use the following credit/debit card for the purpose of making automatic payments (optional):

Name on Card: _____ Card #: _____

Exp. Date: _____ CVV Code: _____ Signature: _____

Still Waters
Counseling

Assignment of Insurance Benefits

Client Name: _____

Insurance Company: _____

Claims Mailing Address: _____

_____

I hereby authorize the direct payment of all insurance benefits to Still Waters Counseling for all psychological services rendered.

_____ _____

Client Signature Date