Center for Solutions

Client Name: _____ Male_____ Female_____
(First) (Middle initial) (Last)
Date of Birth: ____/____/____ Social Security Number:____-____-____
(Not needed if client is a minor)
Address:_____City:_____ State:_____ ZIP:_____
Home Phone: (____)_____ Marital Status: _____ Spouse's Name: _____
Cell phone: (____)_____ Email: _____

☐ I give Center for Solutions staff permission to leave a voicemail on the given phone number mailbox
Client Employer/School: _____ Work Phone: (____)_____
Who Referred You Here: _____

For Minors:
Child lives with: Both Parents_____ Mother_____ Father_____ Other:_____
Mother:_____ Address:_____
(if different)
Date of Birth:____/____/____ Social Security Number: ____-____-____
Home Phone: (____)_____ Cell Phone: (____)_____
Place of Employment:_____

Father:_____ Address:_____
(if different)
Date of Birth:____/____/____ Social Security Number: ____-____-____
Home Phone: (____)_____ Cell Phone: (____)_____
Place of Employment:_____

Insurance Information:
Primary Insurance Co.:_____ Member ID#:_____ Group #:_____
Policy Holder:_____ Date of Birth:____/____/____
(First) (Middle Initial) (Last)
Social Security Number:____-____-____ Employer:_____
Client's Relationship to Cardholder: Self_____ Spouse_____ Dependent_____

Secondary Insurance Co.:_____ Member ID#:_____ Group #:_____
Policy Holder:_____ Date of Birth:____/____/____
(First) (Middle Initial) (Last)
Social Security Number:____-____-____ Employer:_____
Client's Relationship to Cardholder: Self_____ Spouse_____ Dependent_____

Identification of other physicians/healthcare entities involved with my medical care whom I authorize ongoing release of information for continuity of care:
Primary Care/Referring Physician:_____ Phone: (____)_____
Address:_____ State:_____ ZIP:_____

I understand that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information provided on the office policies and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____

Client Signature or Parent Signature if Client is a Minor **Today's Date**

Center for Solutions

Welcome to Center for Solutions in Brief Therapy, Inc.

Office Policies for Services Rendered

Updated to take effect on January 1, 2018

In order to ensure that you have been informed about our office policies, we would appreciate that you review the following information and sign.

NOTICE OF POLICY CHANGE

Effective **January 1, 2018**, Center for Solutions in Brief Therapy will be revising our financial policy. Please ensure that you have read the updated policy information.

NEW AND EXISTING CLIENTS: Completion of new client forms, including the Credit Card Authorization Form, along with copies of insurance cards will be required beginning January 1, 2018.

FINANCIAL POLICY

As a courtesy, Center for Solutions in Brief Therapy may verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we receive, you are still liable for any balance. It is ultimately your responsibility to understand your benefits, to verify the provider or group is in network, and to pay any balance you may incur.

It is the policy of Center for Solutions in Brief Therapy that payment is due at the time of service unless other financial arrangements are made in advance. Copay amounts will be billed to your card on file at the time of service. Plans with deductible amounts and/or coinsurance amounts will be sent to your insurance company to process. After your insurance processes the claim, the remaining amount owed will be charged to your card on file automatically. In the case of dual coverage, both policies will be billed prior to collecting payment from the patient.

We reserve the right to cancel your appointment or discontinue treatment if your account reflects an unpaid balance. If you are not able to pay for your services, we will assist you in locating an alternate community mental health provider who may be able to work with your financial situation.

Please ensure that up to date information is kept on file at all times. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances.

Although we are contracted with most insurance carriers, our services may not be covered by your particular plan. **Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.**

CREDIT CARD ON FILE

At Center for Solutions in Brief Therapy, we require keeping a credit card on file to ensure payment for the portion of services that your insurance doesn't cover but for which you are liable. **Without this authorization, a paper billing fee of $10/month will be added to your account PER MONTH for any balance that we must attempt to collect through mailing a statement. This requirement does not apply to Medicaid clients.**

Center for Solutions

Your credit card information is kept confidential and stored in a secure processing system. The paper authorization will be destroyed upon entry of the card into the system. Center for Solutions in Brief Therapy will charge copay amounts at the time of service. Any remaining balances that apply toward deductible, coinsurance, copay or denials will be charged immediately after the claim has processed. Any overpayments will be credited promptly to the same card. Charges for no show or late cancel fees will also be charged to the card on file. Your insurance company cannot be charged for no show or late cancel fees. Your signature indicates you understand that you are 100% responsible for these fees. Please be sure to review the no show/late cancel policy.

You may call our office to pay your balance over the phone or to obtain the forms to keep your credit card on file. You may mail in a check for payment, but any account that has a balance which results in a statement being mailed will be subject to the billing fee and outstanding balance charge after March 1, 2018.

What if I don't have a credit card?

If you do not have a credit card, you can continue to pay via cash or check either in person or through the mail. However, if your account produces a balance and a statement is generated, you will be charged the fees. Therefore, it will be increasingly important to call in, check on your balance, and stay on top of it to ensure this does not happen. Knowing your benefits and paying before your appointment will also be helpful.

What if I already have payment arrangements on my account?

We will honor any payment arrangements that have already been previously set up and are being kept as promised. If you fail to keep your payment arrangements, we will revert to the new policy.

What if I want to use my HSA account?

You can enter your HSA card on file to use as your credit card. You will be responsible for ensuring there are funds available to cover your fees. If your HSA card does not have funds available, you will need to use an alternate card.

What if I don't want to put my credit card on file?

If you do not put a credit card on file, you will need to be well aware of your benefits and ensure that your account is paid in full at all times. Failure to do so will result in the paper billing fee being added to your balance as outlined in the policy.

What if you make a mistake on my account?

If you believe something is wrong with your account or charges, please do not hesitate to ask. We can always make an adjustment and refund any funds to your card if necessary.

How will I know what the charges are for?

Most insurance companies will send you an Explanation of Benefits (EOB) indicating your patient responsibility. If they are not sent to you, most insurance companies also have online access for their members to see the information. You can match your EOB to the charges on your account. You can also request a print out of your account through the front desk at our office. Do not hesitate to ask if you have any questions. We are always happy to help!

Center for Solutions

General

- Confidentiality – The therapeutic relationship is based on confidentiality. Neither the therapist/supervisor, nor any employee at Center for Solutions in Brief Therapy, Inc. will divulge information about any client without the client's written consent with the following exceptions:
  - When required by the individual's insurance, the client having signed a waiver when signing the insurance.
  - Information will be provided to the referring physician, when applicable.
  - When it is felt that the client is in danger to himself or others.
- The professional client – therapist relationship will remain so throughout therapy: dual relationships, i.e. friend/therapist, business partner/therapist are not permitted.

Fees

- **After the first missed appointment, you will be charged the full amount of $130.00 for all subsequent missed appointments, unless the office staff is notified at least 24 hours prior to your set appointment time. If you do not allow 24 hours in advance to cancel your appointment, you will be charged $65 as a late cancellation fee. We have a voicemail available 24 hours a day and seven days a week to leave a message to cancel your appointment**. This is necessary because there is usually someone waiting to be scheduled, someone who could have used the time slot that was reserved for you. Insurance companies will NOT allow us to bill them for any missed appointments. Therefore, when we do not have the benefit of a 24 hour notice, you will be billed directly for the entire amount of the missed appointment and you alone will be responsible for paying the fee.
- If your account were to become past due, the person listed as being financially responsible for your account may be sent to our collection agency. **Any account that is over 90 days past due with no payment arrangements will be sent to collections. There is a $25 collection fee if an account is sent.**

Payment

- **We will bill your insurance company as a courtesy to you. If your insurance company fails to pay for your services, you will be held responsible. Copayments are due at the time of service. If you are unsure of your insurance coverage and we are unable to verify your benefits, we will require full payment at the time of your visit until the exact amount of your co-payment is determined. We reserve the right to reschedule your appointment if you do not have your payment.**
- **We are extending the option to keep a credit card on file that is authorized for copayments and unpaid balances. Your credit card will be billed automatically.**
- In the case of divorce, the parent or guardian who is bringing the child in for services will be held responsible for payment, regardless of divorce decree.

Your signature below indicates your understanding of our policies and your agreement to pay for services rendered.

_____ _____

Client Signature or Parent Signature if Client is a Minor **Today's Date**

Center for Solutions

Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare

I understand that as part of my healthcare or the healthcare of my minor child, Center for Solutions in Brief Therapy, Inc. originates and maintains health records for describing my health history, symptoms, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routing healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals.

I understand that I have the option to be provided a HIPAA Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent and will ask the receptionist if interested. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

- I request the following restrictions to the use of disclosure of my health information

_____

_____

_____

_____ _____

Client Signature or Parent Signature if Client is a Minor **Today's Date**

_____ _____

Witness Signature **Today's Date**

Informed Consent to Receive Mental Health Treatment

I, _____, hereby voluntarily consent to, and authorize, Center for
(Client Name or Parent/Guardian Name of Minor)
Solutions in Brief Therapy, Inc. to render mental health treatment to myself and/or minor child. The treatment plan and/or form of treatment to occur will be discussed with me. I understand that I can, at any time, withdraw my consent in writing.

_____ _____

Client Signature or Parent Signature if Client is a Minor **Today's Date**

_____ _____

Witness Signature **Today's Date**

Center for Solutions

Psychological Evaluations and Testing Clients

Thank you for choosing Center for Solutions in Brief Therapy, Inc. for the purpose of psychological evaluation of possible learning disabilities, attention-deficit/hyperactivity disorder, developmental delays, personality/emotional issues, and in some cases, memory problems and weight-loss management.

At Center for Solutions in Brief Therapy, Inc. we attempt to be comprehensive and thorough in the assessment of any given problem.

Your first visit will be an initial interview intake session. Testing will begin at the next appointment, with the exception of Dr. Johnston and Dr. Foreman's bariatric clients. Psychological testing is billed based upon time spent administering, scoring, and interpreting the testing materials. Your insurance may pay testing visits at a different rate than therapy sessions. The amount of time required to complete the process will be dependent upon the type of evaluation you are receiving. This will be discussed at the time of scheduling.

Once the testing is completed, the client (or parent of) will meet with one of our psychologists to discuss testing results and recommendations. The psychologist will explain your options for receiving a full report and sending the report to your physician, school, etc.

If you have any questions please discuss them with the office staff or any of the therapists.

Your signature below will indicate your understanding of our policies and your agreement to pay for services rendered.

_____ _____

Client Signature or Parent Signature if Client is a Minor **Today's Date**

Thank you for choosing Center for Solutions in Brief Therapy, Inc.

Our Mission

Develop a vision and goals for your life as you move forward into the future.

"Success is to be measured not so much by the position that one has reached in life as by the obstacles which he has overcome."

(Booker T. Washington)

Our Approach

Center for Solutions' approach is brief therapy which focuses on solutions not on problems, pathology, causes of problems or even how problems are maintained. Our approach facilitates realistic, achievable, specific, and behaviorally defined goals. Brief Therapy utilizes the importance of homework assignments, reframing, humor, and paradoxical tasks as facilitators for client-generated solutions.

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www.centerforsolutions.net