Central Ohio Counseling, Inc.
A Professional Corporation

For Staff Use:
Assigned Clinician_____

Case #_____

Case Opened/Ins. Processed by:_____

INTAKE PACKET

Today's Date_____ Clinician Name_____

Is/Has a family member /spouse /significant other /housemate being/been treated by a clinician at COC? If so, who and what clinician is/was providing treatment?

_____

Client Name_____
First Middle Last

Mailing Address_____
Street # & Name City, State, Zip

Phone_____ _____ _____
Home Work Cell

Date of Birth_____ Sex_____ Social Security #_____

Marital Status: S M W Spouses Name_____

Emergency Contact_____
Name Relationship to Client

Emergency Contact Phone #_____

Responsible Party Info-

If the client is not financially responsible for payment of services, please complete the following information concerning who is responsible for payment (Parent, Guardian, etc.)

Responsible Party Name_____
First Middle Last

Street/Mailing Address_____

City_____ State_____ Zip Code_____

Social Security #_____ Date of Birth_____

Relationship to Client_____ Home phone_____ Work phone_____

Currently Central Ohio Counseling accepts <u>most</u> commercial insurances; however it is the <u>client's responsibility</u> to verify that the clinician he/she is seeing is in their insurance network.

Insurance Information

********Please note it is the client's responsibility to notify Central Ohio Counseling, Inc. when they have a change in insurance information.

Primary Insurance Co. Name_____

Subscriber's Name (if different from client)_____

Subscriber's
Address_____
Street # & Name City, State, Zip

Subscriber's Phone #_____ Subscriber's Social Security #_____

Subscriber's Date of Birth_____ Employer_____

Subscriber's relationship to client_____ Subscriber's Sex M F

Secondary Insurance Co **COC as a courtesy to our client's will bill secondary insurance. It is the client's responsibility to check with their secondary insurance to see if the provider is in network with their insurance plan.

Name _____

Subscriber's Name (if different from client)_____

Subscriber's
Address_____
Street # & Name City, State, Zip

Subscriber's Phone #_____ Subscriber's Social Security #_____

Subscriber's Date of Birth_____ Employer_____

Subscriber's relationship to client_____ Subscriber's Sex M F

Release of Information Authorization to Third Party

I (we) authorized Central Ohio Counseling, Inc., a professional corporation and/or the professional mental health clinicians who provide services to me (us) to disclose any pertinent case information included but not limited to: diagnosis, case notes, psychological reports, testing results or any other requested information to my third party payer or insurance company for the express purpose of receiving payment reimbursement for services rendered.

I (we) 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. I (we) understand that this consent will not expire until all outstanding charges have been satisfied. I (we) may revoke this consent at any time by providing written notice.

_____ / _____ _____
Client Signature | Client Printed Name | Date

_____ / _____ _____
Responsible Party Signature | Responsible Party Printed Name | Date

_____ / _____ _____
Parent/Guardian Signature | Parent/Guardian Printed Name | Date

_____ / _____ _____
Witness Signature | Witness Printed Name | Date

Central Ohio Counseling, Inc. Financial Policy

The professional staff of sole proprietors at Central Ohio Counseling, Inc. A Professional Organization (hereafter referred to as COC) are committed to providing caring and professional mental health care to all of our clients/patients. As part of the delivery of mental health services, we have established a financial policy which provides payment policies and options to all consumers. The financial policy of COC is designed to clarify the payment policies as determined by the management of COC.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company, unless as is often the case, our providers are in contract with the managed care corporation that administers your mental health plan. In those situations, such as with UHC(UBH), Anthem(Magellan), Anthem(Value Options),etc., the client/patient is only responsible for their copay, co-insurance or deductible amount as defined by their insurance plan. **Currently Central Ohio Counseling accepts most commercial insurances; however it is the client's responsibility to verify that the clinician he/she is seeing is in their insurance network.**

The client or responsible party, as noted on the intake packet, will be financially responsible for payment of all fees, not covered by insurance companies or third party payers after 60 days, except in cases when your provider is contracted with the managed care company that administers your plan. If your insurance is with a managed care corporation, you are only responsible for the copay terms specified in your plan. Any payments owed by the client/patient, and not received after 90 days, are subject to collections.

Insurance deductibles and copays are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, this amount will be collected by COC until the deductible payment is verified to COC by the insurance company or third party provider.

The adult accompanying a minor (or guardian of the minor) is responsible for payment for the child at the time of service. Unaccompanied minors may be denied non-emergency services unless charges have been pre-authorized to an approved credit plan or credit card.

All insurance benefits will be assigned to COC or your clinician (by insurance company or third party payer) unless the person responsible for payment of account pays the entire balance prior to each session. COC does not currently bill secondary insurance, but is subject to change in the future.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged a rate noted in the "Patient Responsibility for Fees Not Covered By Insurance". I understand that this fee will be billed to my account and that I am responsible for payment prior to my next appointment. If payment for the missed/cancelled appointment is not made prior to my next appointment I understand that my current appointment may be cancelled at the discretion of my provider.
If you have any questions regarding this financial policy please contact the billing department at 614-785-1115.

I (we) have read, understand and agree with the provisions of the Financial Policy.

_____ _____

Signature of Person Responsible for Payment on Account | Date

_____ _____

Witness Signature | Date

Pharmacy Benefit Information

Mail order pharmacy name:_____

Mail order pharmacy phone #_____

Prescription card member ID#_____(please obtain card copy)

Retail pharmacy name:_____

Retail pharmacy phone #_____

Please be advised if you are being treated by one of our physicians and are being prescribed medication(s). If you are in need of a refill please call our office to request this refill. Your doctor will not honor faxed prescription requests from your pharmacy.

****PLEASE NOTE: IT IS AT YOUR DOCTORS DISCRETION TO WRITE PRESCRIPTIONS FOR CONTROLLED MEDICATIONS; BELOW ARE SEVERAL COMMON MEDICATIONS THAT ARE IN THIS "CONTROLLED" CATEGORY (THIS IS NOT AN EXHAUSTIVE LIST):**

- **VYVANSE**
- **ADDERALL (DEXTROAMPHETAMINE/AMPHETAMINE SALT COMBO)**
- **CONCERTA (METHYLYPHENIDATE)**
- **DEXEDRINE (DEXTROAMPHETAMINE SULFATE)**
- **FOCALIN (DEXMETHYLPHENIDATE)**
- **RITALIN (METHYLPHENIDATE HCL)**
- **ATIVAN (LORAZEPAM)**
- **VALIUM (DIAZEPAM**
- **XANAX (ALPRAZOLAM)**
- **KLONOPIN (CLONAZEPAM)**
- **AMBIEN (ZOLPIDEM)**
- **LUNESTA**

****ALSO PLEASE NOTE THAT IF YOU ARE CALLING IN FOR A REFILL ON YOUR PRESCRIPTION PLEASE ALLOW 2 BUSINESS DAYS FOR THIS REQUEST TO BE ADDRESSED. SOME OF THESE PRESCRIPTIONS MAY NOT BE CALLED IN TO YOUR PHARMACY BUT REQUIRE A WRITTEN PRESCRIPTION.**

Central Ohio Counseling, Inc.

Patient Responsibility for Fees Not Covered by Insurance

All fees are at the discretion of your provider(s) and are due prior to request being completed. Please initial your acknowledgement of these fees.

Telephone Requests for Prescriptions

$25 fee will be collected from clients making a telephone request for a prescription as a result of a broken/cancelled appointment, lost prescription or failing to schedule an appointment time prior to running out of their medication. Payment must be made prior to receiving the prescription. This fee applies to both written prescriptions and those called/e-scripted to your pharmacy.

Disability Paperwork/Forms

$75 service fee plus $40 per page (over 1 page in length) fee will be collected for completion of disability paperwork/forms. Payment must be received before paperwork is released to either the client or disability company.

Reports, Letters & other Correspondence

$50 for the first page and $75 for each subsequent page for letters, reports & other correspondence. This includes, but is not limited to, letters to attorneys, other healthcare providers and educators.

Telephone Consultations

Fees for telephone consultations will be $125 for therapists and $150 for MD's to speak with family members, attorneys, school personnel, etc. and only with a signed release from the patient.

***** Broken appointment/Cancelled appointment*****

$120 fee is charged for a new appointment for MD's and a $60 fee for all other broken (missed) appointments and for cancellations made less than 24 hours prior to the scheduled appointment time. If after 2 broken/cancelled appointments it is up to the provider if the client/patient will be allowed to schedule again. As a courtesy COC attempts to remind clients/patients of their appointment 24 hours prior to their appointment time, however it is the client/ patient's responsibility to know when and at what time their appointment is scheduled. Not receiving a reminder call is not an excuse for broken or late cancelled appointments.

Please acknowledge that you understand that these fees will be assessed and are on a cash pay basis only, that they cannot be billed to your insurance company.

_____ _____

Signature of Client/Patient **Date**

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Consent for Treatment

For Adults Receiving Services:

I hereby give my consent to receive treatment and related services from the designated professional(s) providing services to me at Central Ohio Counseling, Inc. I understand that this consent is for the duration of services to be provided.

_____
Client's Printed Name

_____ _____
Client's Signature Date

_____ _____
Witness Signature Date

If Client is a Minor, Parent or Guardian must sign:

I hereby give my consent, as parent or guardian, of the below stated minor to receive treatment and related services from the designated professional(s) providing services at Central Ohio Counseling, Inc. I understand that this consent is for the duration of services to be provided.

_____
Client's Printed Name

_____
Parent/Guardian's Printed Name

_____ _____
Parent/Guardian's Signature Date

_____ _____
Witness Signature Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This form is an easy to understand explanation of HIPAA. A more complete explanation can be obtained through the United States Department of Health and Human Services. www.hhs.gov There are rules and restrictions on who may see or be notified of your Protected Health Information(PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides you with certain rights and protections as a client. We have adopted the following policies and procedures:

1. Client information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Client files will be stored in a secured location when staff is absent. The normal course of providing care means that such records may be left, temporarily, in administrative areas such as psychiatric assistant locations. You agree to the normal procedures utilized in our office for the handling of charts, client records, PHI and other documents or information.
2. As a courtesy COC attempts to remind patients of their appointments. We may do this by telephone, email, US mail, text message or by any means convenient for the practice and/or requested by you, the client/patient. We will not disclose any PHI in this manner.
3. The practice utilizes vendors in the conduct of business. All vendors are required to sign a HIPAA compliant confidentiality agreement.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies and/or insurance payers in the normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to your provider or the practice manager.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide clients/patients with access to their records in accordance with federal and state laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both COC and/or the client/patient.
9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within our office concerning your PHI. However we are not obligated to alter internal policies to conform to your request.

I, _____, on _____, do herby consent and
Name Date
Acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent change in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____
Signature of Client/Patient Date