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_____ _____
Cell Alternate phone

Date of Birth_____ Gender_____

Marital Status: S M D W Email: _____

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 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 we 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 Date of Birth_____ Employer_____

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

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

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Consent for Treatment

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 and for all treating providers.

_____
Client's Printed Name

_____ _____
Client's Signature Date

_____ _____
Witness Signature Date

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 Date

_____ _____
Witness Signature Date

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, Central Ohio Counseling providers, as part of my psychotherapy and/or medication management. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. I understand that Central Ohio Counseling providers will only use a HIPAA compliant telehealth platform to conduct telemental health appointments.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that I must use a computer, tablet, or smartphone that has both a camera and audio functions so that we are able to see and hear one another. I also understand that I must choose a quiet place, free of distractions and other people to conduct our telemental health appointments. At no time will these appointments be held in a public place or setting. I also understand that I should use a private, secure Wi-Fi network to conduct appointments, public Wi-Fi networks are not recommended.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 614-785-1115 option 2 to discuss since we may have to re-schedule.

7) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

Emergency Protocol

You agree to inform me of the address where you are at the beginning of each visit. I also must keep on file an emergency contact. Your emergency contact will only be used in a life-threatening emergency. My emergency contact is:

Name_____ Relationship_____

Phone_____ Alternate phone_____

I have read the information provided above and discussed it with my provider. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Printed Name of Client Signature of Client

_____

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 3 BUSINESS DAYS FOR THIS REQUEST TO BE ADDRESSED.**

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

Balance Notification Preference

After we have processed your claims through insurance, we will send you a statement of what is owed on your account. We give you 3 options of how to receive this statement. Below, please choose one option to receive your balance notification:

____ Paper Statement mailed via USPS
____ Email electronically Email Address:_____
____ Text message via SMS to cell phone Phone#_____

If you choose Email or text message you are giving us permission to contact you through electronic means.

Cash Pay Clients

For clients that do not have insurance and will be paying out of pocket, Central Ohio Counseling requires that a valid credit card be put on file for all charges incurred with treatment. Your credit card will be charged the morning of your scheduled appointment. If the card declines, we will cancel your appointment. Cash prices are determined by each individual provider and vary in price. When scheduling, our intake scheduler or front desk receptionist will tell you what your provider's prices are for new client appointments and existing client appointments. Pricing ranges from $200-$250 for new client appointments and $175-$100 for existing client appointments. Central Ohio Counseling does not take Medicaid products. This includes:

UnitedHealthcare Community Plan
Molina
Caresource
Buckeye Health Insurance

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. Some physicians require payment of broken or late cancelled appointments prior to rescheduling 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**

Communication Authorization Form

Your physician and staff at Central Ohio Counseling, Inc. (COC) may need to use your **name, address, and phone number**, to contact you with appointment reminders, discuss treatment, obtain information for refills, etc. When reaching out we will use the address & phone number(s) provided by you on your intake form. If you are unavailable to answer your phone we will leave a message stating your first name, our company name, our phone number & ask that you return our call. We will not leave a message with specific PHI.

Appointment reminders are sent out 2 days prior to your appointment. These reminders are interactive where you will need to confirm or cancel your appointment. When cancelling your appointment you will need to call our office to reschedule, our staff will not automatically call to reschedule a cancelled appointment. You have 3 options for appointment reminders, phone, email or text. By signing below you give Central Ohio Counseling, Inc. permission to contact you by your desired method. If at any time you choose to not receive communication from us regarding appointments or if you want to change your communication method please notify us in writing.

Please choose an 1 option below for your appointment reminder:

____Phone call & message

____Text message to a mobile device. Fees may apply, please check with your phone carrier.

____Email to the address provided_____

____Please do **NOT** remind me of my appointments.

By signing below, you understand that text messaging and email are not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. COC and our affiliates take every precaution to protect your information.

I understand and consent to be contacted by the above communication method. I accept the risk explained above and consent to electronic or automated communication if that is my preference.

Printed Name:_____ Date:_____

Signature:_____

Provider Name: _____

Attendance Policy

We make every effort to remind you of your appointment, however there are times when our service has technical difficulties. Please understand that it is the patient's responsibility to know when their appointment is scheduled and that not receiving your reminder does not exempt you from our attendance policy.

Late Arrivals: If you arrive more than 15 minutes late it is the provider's discretion as to whether you will be seen for your scheduled appointment or if you will need to be rescheduled.
Cancellations: If your appointment is not cancelled 24 hours in advance you will be charged a late cancellation fee of $60
Missed Appointments (No Show)-if you fail to attend an appointment the fees are as follows:
New Patient with a doctor $120
Established doctor appointment or therapy appointment $60

Credit Card Authorization Form

It is the policy of Central Ohio Counseling that all first time (new patient) appointments be secured with a credit/debit card to ensure that the appointment is attended. The fee of $60 will be charged to the card for any missed or late cancelled appointments. **We will not charge your card unless you miss your appointment, or you do not cancel the appointment 24 hours in advance.**

For your convenience we give you the option of keeping your credit card on file with us to charge any copay or deductible amounts, this is not mandatory, but merely a courtesy.

I authorize Central Ohio Counseling to keep my signature on file and to charge the credit card selected below for the following:

☐ Copay or deductible amount $_____for

- ☐ This appointment only
- ☐ All in office or telehealth appointments

Client Name_____

Cardholder Name_____

Cardholder Address_____

_____

Credit Card Type:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number_____

Expiration Date _____ Security Code_____

Cardholder Signature_____ Date_____