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/Sex/Pronouns_____________________

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 most commercial insurances; however it is the client's responsibility 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____

Group #______________________ Member/Subscriber ID______________________________

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.

Secondary Insurance Co, Name ____

Group #______________________ Member/Subscriber ID______________________________

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.

____ ____________________________

Patient/Guardian Date

Consents & Policies

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

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/Guardian Printed Name

____ ______________________

Client/Guardian 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

<u>MEDICATION REFILL POLICY</u>

Central Ohio Counseling has the following policies regarding requesting refills on medication. In almost all circumstances you will need an appointment to receive a refill on medication. By law providers are required to see patients once every 3 months to prescribe controlled medications, these include, but are not limited to the following:

****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)**

ADD/ADHD: If you are being prescribed stimulant medications like Vyvanse, Adderall, etc. we require an office visit once every 90 days. **<u>You will not receive a refill or new prescriptions for these types of medication outside of an office visit.</u>**

Anxiety: Benzodiazepines, such as Xanax, Ativan, etc. have a risk of addiction or dependence and for this reason our providers are very careful about prescribing them for long term anxiety. Our office requires an appointment every 90 days to obtain refills on these types of medications. Our office will not authorize these types of medications to be filled early.

Due to the shortage of providers specializing in psychiatry in the Central Ohio area, our providers schedules fill quickly. It is HIGHLY RECOMMENDED that immediately after an appointment you call our office to schedule your next appointment, otherwise you may not be able to schedule your appointment within your 90 day window. Waiting to schedule your next appointment may result in you not having enough medication until your next appointment. Again, we will not send a refill for these types of medications outside of an appointment.

<u>Guidelines for requesting refills:</u>

- We do not accept refill requests after 12pm on Friday, Saturday, Sunday or holidays, any requests made during these times will be processed on the next business day

- Before requesting a refill, please check with your pharmacy to see if you have any prescriptions on file.
- We do not accept faxed refill requests from your pharmacy. If you need a refill, you must reach out to our office to request these.
- For refill requests on non-controlled medications please allow 72 hours (3 business days) for these to be completed. If you've not had an office visit within the last 90 days, you will be required to make an appointment with your provider. Your provider will send enough medication to get to your next appointment.
- Your provider reserves the right to charge for any refill that is sent outside of an appointment. Please see "fees not covered by insurance" for cost information.
- New symptoms/adverse reactions may require an office visit before new medication is prescribed.
- Patients must follow the prescription directions. If the patient takes it upon themselves to increase a medication and runs out of medication early, your provider will not refill the medication.
- If your prescription is stolen or lost, a police report must be filed with no exceptions. Our office needs to be notified immediately of the lost/stolen medication, the date the medication was lost/stolen, and we will require a copy of the police report. No refills well be provided without this documentation. Be advised that your insurance may not cover a refill if your medication was lost/stolen.
- Your provider reserves the right to not refill a medication if you are non-compliant in keeping appointments or if you do not schedule an appointment in a timely manner.
- Any suspected misuse or sale of prescribed medication, if you have other prescribers prescribing the same controlled medications as your COC provider, if you are non-compliant in keeping scheduled appointments, etc. your prescriber may terminate the physician-patient relationship and you will need to seek services outside of our office.

I have read the Medication Refill Policy and will abide by all terms and conditions contained therein.

_______________________________ _______________________
Patient 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 #____

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.

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 is declined, 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 your request being completed.

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, if your provider is willing to complete these 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.

I (we) have read, understand and agree to the provisions of the Financial Policy, Cash pay policy and Patient Responsibility for Fees Not Covered Policy.

____ __________________
Signature of Person Responsible for Payment on Account Date

____ __________________
Witness Signature Date

Disability Forms Policy

It is at the sole discretion of the provider whether he/she will complete disability paperwork. No provider at COC will complete disability paperwork at the first appointment. Paperwork will only be completed after a solid therapeutic relationship has been established between provider and patient. Requests for paperwork to be completed must be submitted to your provider in a timely manner, usually allowing up to 14 days for completion. An appointment may be needed to complete paperwork. There may be a fee (see Fees Not Covered by Insurance) for completing paperwork.

<u>Communication Authorization Form</u>

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, balance notifications, 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.

You have 3 options for communication with our office, please check below your desired method of communication. By signing below you give Central Ohio Counseling, Inc. permission to contact you by your desired method. If at any time you choose not to receive communication from us regarding appointments or if you want to change your communication method please notify us in writing.

Please choose 1 option below for your preferred method of communication:

____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 **<u>NOT</u>** remind me of my appointments.

<u>Balance Notification Preference</u>

If you have an outstanding balance, after claims have processed or if you are self pay, we will send you a balance notification, we do this electronically, please choose either email or text message below:

_____ Email electronically Email Address:____

_____Text message via SMS to cell phone Phone#_____________________________

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__________