CHOICES COUNSELING SERVICES

Patient Registration

Last Name_____ First Name _____MI_____
Address_____City_____State_____Zip_____
Home Phone _____Work _____Cell_____
SS#_____Date of Birth_____Sex: Male [] Female []
Primary Care Physician_____
E-mail Address: _____May we contact you at this address: yes[] No[]
Occupation_____Employer_____
Student: Yes [] No [] Grade_____ School_____
Emergency Contact_____Relation to client_____Phone#_____

Have you received prior Mental Health Treatment? Yes [] No []
Is there a pre-existing condition clause on your insurance? Yes [] No []
If you have a pre-existing clause on your insurance, payment is expected at the time of service. Your insurance will not pay for services until the pre-existing date is met.

Relationship to Insured: [] Self [] Spouse [] Child [] Other
Marital Status: [] Married [] Single [] Widow [] Divorced [] Separated
Ethnicity: [] Caucasian [] Hispanic [] Native American [] Other

RESPONSIBLE PARTY AND-OR INSURED INFORMATION

Last Name_____ First Name _____MI_____
Address_____City_____State_____Zip_____
Home Phone _____Work _____Cell_____
SS#_____Date of Birth_____Sex: Male [] Female []
Occupation_____Employer_____

PLEASE HAVE INSURANCE CARD READY TO BE COPIED OR FILL ALL INSURANCE INFORMATION BELOW

Primary insured CO Name_____Authorization # If EAP_____
Insured Id# as printed on card _____or Insured SS#_____
Billing Address as printed on back of card
Address_____City_____State_____Zip_____
Phone#_____Group#_____
SECONDARY INSURANCE CO NAME _____
Address_____City_____State_____Zip_____
Phone#_____Group#_____

AUTHORIZATION TO RELEASE INFORMATION-ASSIGNMENT OF INSURANCE BENEFITS

1. I AUTHORIZE the release of all medical information necessary to process claims, including by electronic means.
2. I AUTHORIZE all appropriate benefits be paid to Choices Counseling Services.
3. I AUTHORIZE Choices Counseling Service to notify coordinate care with my primary care provider

Signature_____Date____/____/____

Authorization to Exchange Information with

Choices Counseling Services

I, _____, hereby authorize Choices Counseling Service and

_____(Primary Care Physician) to exchange medical and mental health
(Please print)
treatment information.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocations must be in writing and received by Provider at 313 W Apache Farmington NM 87401 to be effective.

This disclosure of information and records authorized by Client is required for the following purpose:

To improve quality of medical and mental health treatment

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):

_____

_____

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization continues to be protected by the HIPAA Privacy Rule, and applicable New Mexico law may protect such information.

This authorization shall remain valid until: _____

Client's signature: _____Date_____

Choices Counseling Service

Choices strives to provide the most professional counseling services available. We employ a broad range of skills to provide you with the most personalized treatment experience.

As part of our individualized care, we wish to send you reminders that fit your preferences and lifestyle.

How would you like to be reminded of your appointment? (Please only choose 1)

- ☐ Voice Message
- ☐ Text message
- ☐ Email

Name:_____

Telephone Number (If requesting text):_____

Email (If requesting email):_____

Advance Directive for Mental Health Treatment

The State of New Mexico has passed a law **requiring** us to give you the **option** of providing us with an Advance Directive for Mental Health Treatment. This Directive with give us your wishes should you become incapacitated and designates someone who can gives us instructions for your care.

It is **extremely** rare that someone receiving outpatient mental health care should become incapacitated.

However, we wish to fully comply with New Mexico State law.

Should you wish to complete such a Directive, please indicate below and we will provide you with the 11-page form.

Should you not wish to complete such a Directive, please indicate below.

I wish to provide an Advanced Directive for Mental Health Care ☐

I **do not** wish to provide an Advanced Directive for Mental Health Care ☐

Client's signature: _____Date_____

Choices Counseling Services

OFFICE POLICIES & GENERAL INFORMATION

AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices.

Your Therapist is_____

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

When Disclosure is Required by Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will use his/her clinical judgment when revealing such information. Your therapist will not release records to any outside party unless she/he is authorized to do so by all adult family members who were part of the treatment

Emergencies: If there is an emergency during our work together, or in the future after termination, where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she/he will do whatever she/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she/he may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct, only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the information he/she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the, congress-approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently

vulnerable to break-ins an unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and all phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regards to many maters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes. injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: Your therapist consults regularly with other professionals regarding his/her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

> Considering all of the above exclusions. if it is still appropriate. upon your request your therapist will release information to any agency/person you specify unless she/he concludes that releasing such information might be harmful in anyway*

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please leave a message during business hours with the secretary (505) 325-5321 and your call will be returned as soon as possible. If and emergency situation arises, please indicate it clearly in your message. If you need to talk to someone after business hours, you can call the on-call therapist at (505) 325-5321 or the Police (911). Please remember you will be personally billed for the emergency session as a full regular session. We cannot guarantee that your insurance will cover that expense.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $150.00 per 50-minute session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, Consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, we will submit invoices to your insurance company for reimbursement Please be aware that billing does not guarantee payment. You remain responsible for payment for all services rendered. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage and arrange for prior authorization.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your therapist and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan. CHOICES BEHAVIORAL HEALTH SERVICES, INC. can use legal means (court, collection agency, etc.) to obtain payment The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION: Participation in the therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feeling and/or behavior. Your therapist will ask for your feedback and views on your Therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honesty. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member may be viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part; to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

Discussion of treatment plan: within a reasonable period of time after the initiation of treatment, your therapist will discuss with you (client) his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, she/he has an ethical obligation to assist you in obtaining these treatments.

Termination: As set forth above, after the first couple of meetings, your therapist will assess if he can be of benefit to you. Your therapist does not accept clients who, in his/her opinion, she/he cannot help. In such a case, she/he will give you a number of referrals that you can contact. If at any point during psychotherapy, your therapist assesses that she/he is not effective in helping you reach the therapeutic goals, she/he is obliged to discuss it with you and, if appropriate, to terminate treatment, in such a case, she/he would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and if she/he has your written consent, she/he will provide her or him with the essential

information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will offer to provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs your therapist's objectivity, clinical judgment, or therapeutic effectiveness. It also can never be exploitative in nature. Your therapist will enter into non-sexual and non-exploitative dual relationships with clients only after careful consideration. San Juan County is a small community and many clients know each other and your therapist from the community. Consequently, you may bump into someone you know in the waiting room or into your therapist out in the community. Your therapist will never acknowledge working therapeutically with anyone without his/her written permission. Many clients choose Choices as their counseling agency because they know us before they enter into therapy and/or are aware of our stance on the topic. Nevertheless, your therapist will discuss with you the often existing complexities, potential benefits, and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to your therapist if the dual relationship becomes uncomfortable for you in any way. She/he will always listen carefully and respond accordingly to your feedback. Your therapist will discontinue the dual relationship if she/he finds it interfering with the effectiveness of the therapeutic process or the client and, of course, you can do the same at any time.

CANCELLATION: Since scheduling of an appointment involves reserving time specifically for you, a minimum of 24-hour notice is required for re-scheduling or canceling an appointment Unless we reach a different agreement, A $25.00 FEE WILL BE CHARGED FOR ALL NO SHOWS OR CANCELLED APPT'S WITHOUT 24 NOTICE, THIS WILL NEED TO BE PAID BEFORE WE WILL SCHEDULE ANOTHER APPT. Insurance companies will not pay for cancelled appointments or for rescheduled appointment

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:

_____

Client name (print) Date Signature

_____

Parent or Guardian (print) Date Signature

_____

Therapist Date Signature

Choices Counseling Services
Financial Policy

FINANCIAL POLICYAND SERVICE AUTHORIZATION

Thank you for choosing Choices Counseling Service as your mental health care provider. We try to make our services as brief, efficient and timely as reasonably possible. Our rates are comparable to the usual and customary fees charged for similar services in this area. You are responsible for payment in full regardless of your insurance company's arbitrary determination of usual and customary rates. We ask your help in considering payment of your bill as a part of your treatment. The following is a statement of our financial policy, which we ask you to read and require your signature of agreement prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Facility fees are $150.00 per session. We offer a 20% payment discount if you pay this fee on the date of service. We accept credit card, debit card, cash and/or personal checks. With our prior approval, we will accept assignment of insurance benefits or we offer an extended payment plan.

Insurance:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the services we provide may be "non-covered services" or not considered reasonable and necessary under your insurance plan. You are responsible for obtaining Prior Authorization if required by your Insurance Company. If your Insurance requires authorization through our office, we will obtain prior approval. We also will complete and submit insurance claim forms for you. However, we cannot bill your insurance company unless you provide all required insurance information and complete all necessary forms.

Payment:

We may accept assignment of insurance benefits if your visit is approved by your insurance carrier. However, we do require payment of the appropriate deductible and/or co-payment at the time of service. The balance is your responsibility whether your insurance pays or not. If you are unable to pay the full deductible payment or your insurance company has not paid your outstanding balance, the balance due will automatically be billed through the Extended Payment Plan (See Below). If there is no insurance coverage, we require 100% of the session fee to be paid at the time of service. With prior approval an extended payment plan may be arranged.

Extended Payment Plan:

If you require additional time within which to pay your bill, we will then ask that you commit to pay an amount you can afford on a monthly basis. If your bill is not paid in full, we will charge a service fee of 1.5% per month of the unpaid balance.

Minor Patients:

A minor's legal guardian must authorize treatment prior to services being provided. By signing as responsible party, the adult signifies he/she is the child's legal guardian and consents to treatment of the minor child. Parents (guardians) are responsible for payment as per the conditions of this agreement.

Collection Expenses:

If you are unable to pay a portion of fees you owe, please contact us. We do not want unintentional financial problems to get in the way of our positive relationship. We will work with you to make payment possible. We will do everything reasonable and responsible to avoid collections expense. If, however you do not contact us or attempt to pay the amount you owe we will take legal action. If this very unfortunate and avoidable process occurs, you will be responsible for all lawyers' fees, court costs and other collection expenses incurred.

Thank you for cooperating with our Financial Policy.
I have read the Financial Policy and Service Authorization. I understand and agree to this Policy.

_____ _____

Signature of Responsible Party PLEASE PRINT FULL NAME

_____

Patient's Name (if different form responsible party)

Acknowledge Receipt of HIPAA

I acknowledge receipt of HIPAA Notice of Privacy Practices

Please Print Name:

Patient Name: _____

Please Sign:

Patient Signature: _____Date:____/____/____

Parent or Guardian Name if patient is under legal age

Print Name:

Parent or Guardian: _____

Please Sign:

Signature: _____Date:___/____/_____

Choices Counseling Services

Cancellation and Telephone Consultation Policy

Due to the high demand for services we have found it necessary to be more efficient with your care.

Clients will be charged a **$25.00** cancellation fee for each missed appointment ("no show') or failure to notify us of cancellation or rescheduling within 48 hours of appointment. Clients will not be able to reschedule a new appointment until they have paid the **$25.00** fee.

Also clients will be billed **$25.00** for telephone consultations with their therapist or the on-call clinician.

Please be aware that insurance will not pay for these fees. The client is solely responsible for payment of these fees.

I acknowledge Choices Behavioral Health Services Cancellation Policy and agree to pay **$25.00** for failure to comply.

Initial_____

I also acknowledge Choices Behavioral Health Services Telephone Consultation Policy and agree to pay **$25.00** per call.

Initial_____

Signature:_____ Date:___/____/____

Choices Counseling Services

CONSENT TO USE OR DISCLOSE INFORMATION FOR PAYMENT AND HEALTH CARE OPERATIONS (TPO)

Patient Name:_____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the service we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes the disclosures in more detail. You have the right to review the Notice if Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your records that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if that consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health information as specified above.

Signature_____Date_____/_____/_____