ES Counseling, LLC

Financial Responsibility Policy

We are committed to providing you with a clear understanding of the financial policy. If you have any questions or concerns, do not hesitate to ask. Educate yourself with the following and initial that you fully understand each policy:

At each visit, please confirm we have the correct and complete insurance information. We request a copy of your driver's license, valid credit card and current insurance card at the first visit. You will be responsible for any and all deductibles, co-payments and services not covered by insurance. It is your responsibility to stay informed of insurance changes, deductible balances, authorization requirements, etc. Client's initials: ______

At each visit, copayments, co-insurance and payments for self-pay services and balances are due in full at the start of session. *Personal checks are not accepted*. We accept cash, MasterCard and Visa credit cards, debit and Health Savings Account (HSA) cards. If the client is a minor, the adult who brings the child is responsible for paying the fee at the time of service or for paying **<u>prior</u>** to the appointment. It is your responsibility to bring exact change for your payments. No change will be given and any overpayment will be credited to your account. If you are unable to pay on the day of service, please call more than 27 hours prior to your appointment to reschedule your visit to avoid the no sow/cancellation fee. The no show or cancellation fee for appointments cancelled within 24 hours of the appointment is **the rate of the session. Your session rate: $ ____________** Client's initials: ______

It is **required** that you provide credit card information to be kept in your confidential patient record to cover any no show or cancellation fee that you may acquire. Please confirm the card is valid. The card will have a validation transaction completed after your first visit. Your credit card information will be processed in the event of a no show or cancellation and you will be sent a receipt of the transaction to the e-mail address on file. If you choose, your credit card can be kept on file for payments or copayments by initialing below. A $2 service charge will be charged to your account for each 'declined' transaction due to incorrect information provided or for deficit of funds. If you do not leave a credit card, a deposit of your session rate will have to be left in cash with the therapist at the first visit. Client's initials: ______

Telephone calls, e-mails and legal/forensic or other record reviews completed by your provider to coordinate care with parents, attorneys and other non-medical providers will be billed at the rate of $25 per 15 minutes. Completion of medical forms, including but not limited to disability forms, Family Medical Leave Act (FMLA) forms and other reports or letters written for legal or financial purposes require a payment by the client. The fee is dependent upon the length of time used to complete the paperwork, including treatment summaries, and is billed at the rate of $25 per 15 minutes of time. You will be given an estimate of charge and this will be paid prior to completion. Forms will not be completed in session and may take up to 14 business days. It is the therapist's discretion what records will be released and if a treatment summary will be provided in lieu of records. Medical records released directly to other providers for collaboration and coordination of care are complimentary; however if a client requests their own records, the charge is $1 per page and at the rate of $25 per 15 minutes of time for completion. Requests for records will take up to 10 business days, or 14 calendar days depending on when they are requested. Please plan accordingly. Client's initials: ______

If your account requires outside collection efforts, you will be responsible for your balance. A lapse in treatment will not erase the balance due. Prior to sending the statement to a collections service, we will send two courtesy monthly account statements indicating the unpaid balance. After two unpaid statements are sent, no further appointments will be scheduled, and any outstanding appointments will be cancelled until the balance has been satisfied in full. Client's initials: ______

Thank you for your attention and cooperation. By signing below, you understand that regardless of insurance status, you are responsible for your account. You have read the information and understand the policy. Client's initials: ______

Patient Name _______________________________ Guardian Name (if applicable) _______________________
Patient or Guardian Signature ______________________________________ Date ________________________
Form of Payment: (check one) __**Self Pay Rate** ______ __Insurance _____________ __EAP for ____ visits
Credit Card for No Show/Cancellations ONLY: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Exp: ___/____CC CVS code: _ _ _
Name as printed on credit card: _____________________________________Billing zip code for Card: ________
I give my permission to use the credit card above, my card, for co/payments _____ (initials)

HIPAA & Confidentiality Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. The rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

Primary Care Provider or Pediatrician: ____
Address: ____
Phone: __________________________________ Fax : __________________________________
☐ I choose not to release information to my primary care provider regarding treatment received at ES Counseling.

I have also been informed of, and given the right to review the Summary of the HIPAA Privacy Rule, which contains a more complete description of the uses and disclosures of my protected health information (PHI), and my rights under HIPAA. Location: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

Psychotherapy notes do not have to be released unless by judicial court order. For this reason, I understand if notes are requested, a treatment summary may be given in lieu of the notes, and therefore I may incur a charge for this service.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: __________________________________ Relationship to Patient: __________________
Signature: ____ Date: ________________

Social Media Policy

In our best effort to protect your privacy, we will not accept requests or invitations from clients or their first degree relatives for any social media to include, but not limited to Facebook, Twitter, LinkedIn, Pinterest, Instagram, or personal blogs. We have a monitored Facebook business page for ES Counseling and welcome 'likes,' but we will not respond to email or instant messaging through that site. We are appreciative of word-of-mouth referrals, however we cannot confirm or deny past or current client's treatment to potential or new clients. If you choose to write a recommendation on a business review site for ES Counseling, please keep in mind that you may be sharing personal information in a public forum and we encourage you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.
____ I have read and understand this policy on social media