CHOICES COUNSELING SERVICES

Client 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#_____

How did you hear about us?

Doctor_____ Friend _____

Website [ ] Facebook [ ] Other [ ]

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

Allergies: _____

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_____

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. To be effective, I also understand that such revocations must be in writing and received by Provider at 313 W Apache Farmington, NM 87401.

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

To improve the 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 detailed as you choose):

_____

_____

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

The 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: **Date** _____

Client's signature: _____Date_____

Choices Counseling Service

Choices strives to provide the most professional counseling services available. We employ many 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)

☐ Text message

☐ Email

Name:_____

Telephone Number (If requesting text):_____

Email (If requesting email):_____

Client's Last Name_____ Client's First Name _____

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 gives us your wishes should you become incapacitated and designates someone who can provide us with instructions for your care.

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

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

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_____

Client's Last Name_____ Client's First Name _____

Choices Counseling Services

OFFICE POLICIES & GENERAL INFORMATION

AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you (patient) with additional information 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 provisions explaining when the law requires disclosure were described in the Notice of Privacy Practices you received with this form.

When Law requires Disclosure: Some of the circumstances where the law requires disclosure 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 under a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain your therapist's psychotherapy records and testimony. 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 their clinical judgment when revealing such information. Your therapist will not release records to any outside party unless they are 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 safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, they will do whatever they 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, they 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 to process the claims. If you instruct, only the minimum necessary information will be communicated to the carrier. Unless authorized by you, 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 they submit 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 future eligibility to obtain health or life insurance. The trouble stems from the fact that mental health information is entered into insurance companies' computers and will soon be reported to the congress-approved National Medical Data Bank. Accessibility to companies' computers or the National Medical Data Bank database is always in question, as computers are inherent.

Client's Last Name_____ Client's First Name _____

Vulnerable to break-ins and 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 essential to be aware that unauthorized people can relatively easily access e-mail and all phone communication, 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 communication mentioned above 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 matters 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 disclosure of the psychotherapy records be requested.

Consultation: Your therapist consults regularly with other professionals regarding their 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 they conclude that releasing such information might be harmful in any way*

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 an emergency arises, please indicate it clearly in your message. If you need to talk to someone after business hours, call the on-call therapist at (505) 325-5321 or the Police (911). Please remember that you will be personally billed for the emergency session as an entire 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, the 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 therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients, not 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. You are responsible for verifying the specifics of your coverage and arranging for prior authorization.

Client's Last Name_____ Client's First Name _____

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 initiating 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. Even with the preceding, if 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 attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can benefit you, including improving interpersonal relationships and resolving the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires active involvement, honesty, and openness to change your thoughts, feelings, 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 honestly. Sometimes more than one approach can help deal with a particular 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 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 therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem being treated and their 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 the treatment plan: within a reasonable period after the initiation of treatment, your therapist will discuss with you (the client) their working understanding of the problem, treatment plan, therapeutic objectives, and their view of the possible treatment outcomes. 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 the treatment plan, please ask, and you will be answered thoroughly. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any therapy your therapist does not provide, they have an ethical obligation to assist you in obtaining these treatments.

Termination: As stated above, after the first couple of meetings, your therapist will assess if he can benefit you. Your therapist does not accept clients who, in their opinion, they cannot help. In such a case, they will give you several referrals you can contact. If at any point during psychotherapy, your therapist assesses that they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment; in such a case, they would give you several 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 to help with the transition. If you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and if they have your written consent, they will provide them with the essentials.

Client's Last Name_____ Client's First Name _____

Information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will 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 with many clients and therapists from the community who know each other. Consequently, you may bump into someone you know in the waiting room or your therapist in the community. Your therapist will only acknowledge working therapeutically with people with their written permission. Many clients choose Choices as their counseling agency because they know us before they enter therapy and/or know 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 also detract from it; it is often impossible to know that beforehand. It is your, the client's, responsibility to communicate to your therapist if the dual relationship becomes uncomfortable for you. They will always listen carefully and respond accordingly to your feedback. Your therapist will discontinue the dual relationship if they find it interfering with the effectiveness of the therapeutic process or the client; of course, you can do the same at any time.

CANCELLATION: Since scheduling 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 canceled appointments or rescheduled appointments.

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 POLICY AND SERVICE AUTHORIZATION

Thank you for choosing Choices Counseling Service as your mental health care provider. We make our services as brief, efficient, and timely as possible. Our rates are comparable to the usual and customary fees for similar services in this area. You are responsible for payment in full regardless of your insurance company's arbitrary determination of standard and daily rates. We ask for your help in considering your bill payment 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 on the agreement before 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 cards, debit cards, cash, or personal checks. With our prior approval, we will accept the assignment of insurance benefits or 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 our services may be "non-covered" 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 can only bill your insurance company if you provide all the required insurance information and complete all necessary documents.

Client’s Last Name_____ Client’s First Name _____

Payment:

We may accept the assignment of insurance benefits if your insurance carrier approves your visit. However, we require payment of the appropriate deductible and co-payment at the time of service. The balance is your responsibility whether your insurance pays or not. If you cannot pay the full deductible 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 to pay your bill, we will ask that you commit to delivering an amount you can afford monthly. If your account is not paid in full, we will charge a service fee of 1.5% of the unpaid balance per month.

Minor Patients:

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

Collection Expenses:

If you cannot pay a portion of the 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 expenses. If you do not contact us or attempt to pay the amount you owe, we will take legal action. If this unfortunate and avoidable process occurs, you will be responsible for all lawyers' fees, court costs, and other collection expenses.

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

_____ _____

Signature of Responsible Party PLEASE PRINT FULL NAME

_____

Patient's Name (if different from the responsible party)

Client’s Last Name_____ Client’s First Name _____

Acknowledge Receipt of HIPAA

I acknowledge receipt of the HIPAA Notice of Privacy Practices.

Please Print Name:

Patient Name: _____

Please Sign: _____

Patient Signature: _____Date: ___/____/____

The parent or Guardian Name if the patient is under the legal age.

Print Name: _____

Parent or Guardian: _____

Please Sign: _____

Patient 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 the appointment. Clients can only reschedule a new appointment after paying 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 the 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:___/____/____

Client's Last Name_____ Client's First Name _____

Choices Counseling Services

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

Patient Name:_____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record 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 for your consent to make this permission explicit. The Notice of Privacy Practices describes the disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at anytime. The revised Notice will be posted in the office if we do so. 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 healthcare operations; however, we do not have to agree to these restrictions. If we do agree to a condition, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken based on the consent before the revocation.

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

I hereby consent to using or disclosing my Protected Health information as specified above.

Signature_____Date_____/_____/_____

Client's Last Name_____ Client's First Name _____