A BRIEF COUNSELING CENTER
DBA: Healthy Counseling Center
9507 N. DIVISION, HOLLAND BUILDING SUITE A
SPOKANE WA 99218
Phone# (509) 466-6632 Fax# (509) 466-0117

To Our New and Current patients:

Thank you for choosing A Brief Counseling Center. We realize that you have a choice in medical and mental healthcare providers, and we are pleased that you have chosen to seek care with us. The staff at Healthy Counseling Center strives to exceed expectations in care and service to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality mental health care in a timely manner. In order to do so, we have implemented some new policy changes. (see attached form)

As you are well aware, the business of providing insurance-based healthcare is increasingly complex and challenging. For our office to operate effectively and provide the best service to you and your family, we need your cooperation with the following polices. Your clear understanding of these policies is very important to us. Please let us know if you have any questions or concerns.

Furthermore, we strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of everyone do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience.

For safety reasons, we depend on parents to properly supervise their child (ren) always. Our staff cannot watch your children. Under no circumstances should a child under the age of 12 be left unattended.

Sincerely,

Management and Staff

Patient Registration

Welcome to A Brief Counseling Center
DBA: A Health Counseling Center

A Solution Focused Therapist with Expertise in Children and Families

A Brief Counseling Center

The Holland Building ~ Suite A

9507 North Division Street

Spokane, WA 99218-1556

Phone (509) 466-6632

Fax (509) 466-0117

darcybrioso@healthycounselingcenter.com

Patient Information Form

Please print and complete all entries. Thank you!

Patient Information

Name _____ Date of Birth _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____

Employer _____

Social Security Number _____-_____-_____ Driver's License Number _____

Spouse's Information

Name _____ Date of Birth _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____

Employer _____

Social Security Number _____-_____-_____ Driver's License Number _____

Financially Responsible Person (if other than patient)

Name _____ Date of Birth _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____

Employer _____

Social Security Number _____-_____-_____ Driver's License Number _____

Whom may we thank for referring you to us?

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact Information

Name _____ Date of Birth _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____

Primary Care Provider

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

Insurance Information ***A photocopy of insurance cards can be substituted***

Primary Insurance Company: _____

Address: _____

Phone# _____

Name of Policy Holder _____ Date of Birth: _____

Policy number _____ Group# _____

Secondary Insurance Company: _____

Address: _____

Phone# _____

Name of Policy Holder _____ Date of Birth: _____

Policy number _____ Group# _____

Is your condition related to: ❑ Employment ❑ Auto Accident ❑ Other Accident?

Date of First Symptoms: _____ Dates of Similar Condition: _____

Dates Unable to Work: _____ Dates Hospitalized for Condition: _____

A Brief Counseling Center

Thank you for choosing A Brief Counseling Center for your counseling needs! You are in a safe place of hope and healing for the prevention and recovery of relational problems. You can ask any questions you may have about your counseling. Please take a moment to familiarize yourself with the following information.

A Brief Counseling Center's Office Policy

Please initial on each line to acknowledge that you have read and understood the policy.

Sessions are by appointment only, and last 45 minutes each unless we mutually arrange for an adjustment to this policy. The cost of treatment alone will not determine whether you receive counseling with me. The normal fee for the initial intake interview is $225.00, and sessions are $85.00. The appointments scheduled for you are set aside expressly for you and appointments scheduled but not kept will be billed unless canceled 24 hours in advance. Appointments cancelled less than 24 hours will be charged a fee of $85.00 and must be paid in full prior to your next visit. **NO EXCEPTIONS!!!** _____

Telephone consultations are billed at the same rate as regular sessions and fees for any written reports, court testimony, or special testing you may require will be discussed between us prior to those services. These services must be prepaid in advance. If you should decide not to continue with treatment and there is a balance in your account, you will be refunded within 30 days from your last appointment or 30 days from notification that you no longer require these services. _____

Payments on any unpaid balances are due in full before your next session or payment arrangements must be made and kept continuing to seek counseling. There will be a late fee of $30.00 on any payments received late. There will be a $35 NSF fee assessed for all return checks which will need to be paid in cash, credit card, cashier's check, or money order before you next visit. All future payments after that will need to be paid with cash, credit card, cashier's check, or money order. There will be a 1.5% monthly interest charge on any unpaid balance. This agreement shall be governed and enforced by the laws of the State of Washington and venue will take place in the State of Washington, County of Spokane, and City of Spokane. You will receive a statement itemizing your appointments and payments regularly. You may pay for your sessions by cash, check, credit card, cashier's check, or money order. _____

Copays and coinsurance are due at the time of service. _____

In some cases, you may request that I submit claims on your behalf to your health insurance company. Many companies do pay for part of outpatient mental health services, and it is your responsibility to determine the extent of those benefits and what portion of each session's charges is your portion, including annual deductibles or "copayments." It is customary in my practice and required by all insurance companies with which I am contracted that **these copayments are due at the time services are rendered.** Any adjustment of this policy is considered insurance fraud and cannot be adjusted or changed by my office in accordance with my contracts with these companies. If you are not sure what your copayment is, please call your benefits administrator prior to your sessions to determine your financial responsibility in your care. Please be aware that many companies require a diagnosis and occasionally a record of your treatment to determine eligibility for benefits (**see Confidentiality Guidelines**). If for any reason, your insurance company denies benefits to you, you are responsible for all charges.

Confidentiality Guidelines

The State of Washington protects the communication between you and your counselor as privileged and therefore must be confidential. This means that any information you share in session with me is private and that I have the legal and ethical responsibility to keep it confidential. If your treatment includes communication between your spouse, pastor, attorney, etc., and myself, then you must sign a **Permission to Release Information**. Best practices and many insurance companies require that I communicate with your primary care physician about your diagnosis and treatment. There are special circumstances where the law of confidentiality will no longer apply in your treatment.

1. If you report to me or I discover that a child or dependent adult is being sexually or physically abused, or profoundly

neglected, then I am required by law to report this.

2. If I believe that you are dangerous to yourself or others, I am required to contact authorities to protect you or to warn persons who may be in danger.
3. If you cannot care for yourself adequately, I am required to assist you in establishing care and protection.
4. If you decide to bring a civil suit against someone, you waive all rights of confidentiality, in that the court may subpoena my records and request testimony by me concerning the nature of your treatment.
5. If you commit an unlawful act and are charged and brought to a court of law, your records may be subpoenaed and I may be required to testify concerning the nature of your treatment.

Complaints

I hope that if you should have any complaints in the future, you would first call me and offer me an opportunity to answer your questions or to correct any problems. I want to serve you well. If that does not resolve the issue, please contact my supervisor, Dr. Ray Wm Smith, at A Brief Counseling Center, if your complaint is not resolved at that time, then you may contact the Washington State Department of Health, Counselor Program, Professions Quality Assurance Division, Post Office Box 47869, Olympia, Washington 98504-7869. Their telephone number is (360) 664-9098, and for Health Professional Services – Complaints – (360) 586-4561.

_____

Signature of patient/guardian/parent Date

_____

Patient signature (ages 13 to 17) Date

Patients ages 13 to 17

☐ I, _____, give permission to Healthy Counseling Center to release verbal and written results of my mental health records to my parent(s) / guardian.

☐ I, _____, I do not give my parent(s) / guardian permission to obtain my mental health records.

Patient signature (ages 13 to 17) _____ Date: _____

A Brief Counseling Center

DBA: Healthy Counseling Center

The Holland Building ~ Suite A
9507 North Division Street
Spokane, WA 99218-1556

Authorization for Service

I hereby authorize A Brief Counseling to render services to (your name): _____.

I have been provided a copy of the required disclosure information and an opportunity to read and understand the Client Registration Packet. I have had an opportunity to ask any questions about my counseling treatment.

I hereby:

- Authorize the release of any information necessary for the processing of third party payments.
- Authorize the release of any information to my primary care physician or prescribing medical personnel.
- Authorize A Brief Counseling Center to check my credit, employment, and insurance references.
- Assign all medical and or mental health benefits to be paid to A Brief Counseling Center. This assignment will remain in effect until revoked by me in writing.
- Acknowledge receipt of the Notice of Privacy Practices.

A photocopy of this agreement is to be considered as valid as an original. This agreement shall be governed and enforced by the laws of the State of Washington and venue will take place in the State of Washington, County of Spokane, and City of Spokane.

Insurance is not a guarantee of payment; I will pay any costs in full of services rendered or appointment times reserved and not kept (unless canceled 24 hours in advance).

Copays and coinsurance are due at the time of service. Payments on any unpaid balances are due in full before your next session or payment arrangements must be made and kept continuing to seek counseling. There will be a late fee of $30.00 on any payments received late. There will a $35 NSF charged on all return check. There will be a 1.5% monthly interest charge on any unpaid balance.

I understand my rights and responsibilities and those of A Brief Counseling Center as outlined in the packet and agree that its terms may change and to the conditions established by it.

_____

Signature of patient/guardian/parent Date

_____

Patient signature (ages 13 to 17) Date

A BRIEF COUNSELING CENTER
DBA: Healthy Counseling Center
9507 N. DIVISION, HOLLAND BUILDING SUITE A, SPOKANE WA 99218
Phone# (509) 466-6632 Fax# (509) 466-0117

Please initial after each policy change!

Welcome to A Brief Counseling Center. We are honored that you have chosen us as your mental health providers. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner.

We will do our best to provide you quality care in a timely fashion. You will need to bring your insurance card and photo identification with you for each appointment. You will also need to be prepared pay any copay and coinsurance. _____

Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card or unable to pay your copay or coinsurance, your appointment will need to be rescheduled. _____

You will be asked to fill out new registration forms annually (every January) so we may update your information. _____

All past due balances are expected at time of service, unless a prior agreement has been made with our billing department. Any payment arrangements that are made will be strictly enforced. Failure to pay your agreed payment will result in a $35 late fee if payment has not been made within 5 days of agreed paid date. _____

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. If you are more than 15 minutes late, your appointment will be rescheduled and you will be charged a $85 no show fee. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience. _____

We understand that appointments sometime need to be changed, so we ask that you call 24 hours in advance if you cannot keep your scheduled appointment. Otherwise, you may be charged a $85 no show fee or late cancelation fee. Also, no shows appointments will be charged $85 no show fee. This fee will be strictly enforced with very few acceptations. _____

The law authorizes parent(s) or guardian(s) of a minor (anyone under age 18) to give inform consent on most medical decision involving a minor. Minors whose biological parents are not married or no longer married both need to complete client intake packets. Our office policy also requires that we have a copy of the parenting plan that is currently in place, any restraining orders, or other court information that our office deems necessary. There are a few exceptions to this policy. Each exception will be evaluated by the provider prior to scheduling any appointment. _____

You have a right to your medical records; however, our providers must review all medical records request before they are released from our office. For patient ages 13 to 17, they must consent to having their medical records. Our office requires, patient 13 to 17 to complete and sign a release of information. There will also be a medical records charge for all medical records request except for medical records being sent to another healthcare provider. _____

Telephone Consultation are billed at the same rate as a regular session. Email responses will be billed at half the rate of regular sessions. _____

Fees for written reports, court testimony, special testing, and special supervision will be discussed prior to these services. These services must be prepaid in advance. Any funds not used will be refunded back to you within 30 days. _____

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. ***Healthy Counseling Center does not offer chronic pain management and will not dispense chronic pain medication*** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians. _____

2. If you are on a medication that requires refills for a chronic condition (for example Lexapro), you will be given ample refills for 30 or 90 days at a time during your office visit.

    a. When you are down to a 30-day supply of medication, we ask that you call and schedule your follow-up office visit to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you are not without your medication. This holds true for pharmacy faxes for refills. If, we receive a refill request, we will be calling you to schedule an appointment. _____

3. For the safety and well-being of our patients,

    a. Requests for new medications and medication refills will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by one our providers. _____

    b. No new medication will be called in over the phone after office hours or over the weekend. _____

    c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the provider. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills. _____

    d. Our office does not store medications onsite. _____

4. I, the undersigned, accept financial responsibility for payment of all fees at the time of the visit, unless other financial arrangements have been made. _____

5. **ASSIGNMENT OF BENEFITS**: I request that payment of authorized insurance benefits on behave to A Brief Counseling Center DBA: Healthy Counseling Center for any services furnished to me.

    _____

    Signature Date

6. **AUTHORIZATION TO RELEASE INFORMATION**: I authorize any holder of protected health information about me to release to my insurance and its agents any information necessary to determine these benefits or the benefits payable for services. Signature of patient (age 13 to 17) and holder of insurance policy and/or parent or legal guardian must accompany this form.

    _____

    Signature Date

    _____

    Signature (ages 13 to 17) Date

If you need to reach a provider after hours, you can call our office at (509) 466-6632 and leave a message. Messages are checked periodically and call are returned as soon as possible. Our office hours for patient care are Monday through Friday 8am to 5pm and Saturdays 9am to 2pm. (Saturdays phones are not answered, but you can leave a message and someone will return your call that day or the next business day.)

Welcome to our practice and thank you for choosing A Brief Counseling Center for all your mental health care needs.

Form Completion Policy, Letter Policy, Email Policy, and Telephone Policy

Please initial after each policy change!

Patients may require forms to be completed by one of the providers (disability, FMLA, life insurance, MVA, etc.) Completion of forms requires administrative time to gather data and records, providers timer to review, and providers time to complete the form. Some forms are lengthy, complex, and may require additional communication with the patient through email or telephone. To expedite processing these forms in a timely manner, our office has developed the following **Forms Completions Policy, Letter Policy, Email Policy, and Telephone Policy.**

1. If you have seen the provider within the last 30 days, then you may choose to leave the forms and the provider will complete them within 7 business days. There will be a charge of $110.00 to complete the form. If the form takes longer than 60 minutes to complete, is very complex in nature, or requires additional communication with patient either over email or the phone, there will be additional charge of $110.00. If medical records are required, there is a separate charge for this which varies. This must be paid prior to submitting the forms either by the company requesting the information or by the patient. _____

2. Disability, FMLA, insurance policy, and other forms that cannot be completed on the day presented to the office **UNLESS** you have specifically scheduled an office visit for forms completion. When you schedule your appointment, you must inform the receptionist that you have forms to complete, and this is the only reason for your visit. There will be an office visit charge of $85 plus a fee of $110.00 to complete the forms. If medical records are required, there is a separate charge for this which varies. This must be paid at the time-of-service. _____

3. Letters that need to be submitted on our letterhead for medical needs such as an excuse for Jury Duty for a medical condition, special consideration or for accommodations, Declarations for Custody, or other letter requests will be charged a fee of $25.00 per letter. If medical records are required, there is a separate charge for this which varies. _____

4. All emails and phone communication between provider and patient that occurs outside the office visit will be charged to the patient. Emails and phone communication charges will be billed monthly. These charges will need to be paid within 10 days of receiving the bill. The charges will vary depending on the time spent communicating with the provider outside of your office visit. _____

Our office is not obligated to complete these forms. We reserve the right to refuse to complete any form. If medical records are requested, in addition to a complete form, then the form will be sent out office once payment has been received from the company requesting the information or from the patient. No forms or medical records will be sent to a third party without a signed release from the patient and payment has been received in full.

Patient Signature _____ Date: _____

Patient Signature (ages 13 to 17): _____ Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

EMERGENCY CONTACT RELEASE OF INFORMATION

Authorization for Use/Disclosure of Information:

I voluntarily consent to authorize A Brief Counseling Center to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below. I understand that I have a right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____
Address: _____
Phone# _____

Information to be disclosed:

- Acknowledgement of participation in HCC
- Initial assessment and progress notes
- Diagnosis
- Allowance for participation HCC with client
- Recommendations regarding treatment for educational services and placement
- Current behavioral functioning, mental/emotional state and/or education problems
- Informational regarding type of service, medication, client's response to treatment, and prognosis
- Opinion on client's ability to perform employment duties
- Other: information regarding appointment date and times
- School reports (including IPE, teacher questionnaires)
- Collateral information to substantiate mental health concerns, case status, recommendations for services, alerts to special problems, and appropriate treatment
- Legal (including predispositional reports, court orders, and probation contracts)
- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

- ❑ Only the following records or types of health information:

  _____

Term: I understand that this Authorization will remain in effect:

- ❑ One year from the date of this authorizations.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or quality of my treatment at HCC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the A Brief Counseling Center at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the A Brief Counseling Center, 9507 North Division Street, Spokane, WA 99218. Phone (509) 466-6632 or Fax (509) 466-0117

_____ _____

Signature Date

_____ _____

Signature (ages 13 to 17) Date

Healthy Counseling Center
Professional Counseling for Individuals, Couples, Families, Children, and Teens
9507 North Division Street, Suite A, Spokane, WA 99218
(509) 466-6632

CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Healthy Counseling Center** to debit your credit card as listed below.

Patient Name _____ DOB _____

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for counseling services accrued while in treatment with **Healthy Counseling Center** and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I, _____(full name printed) authorize **Healthy Counseling Center** to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments will be charge **$85.00** or failure to provide payment at the time of service will be processed via your credit card for your **copay / coinsurance** per 45-minute session.

Billing Address _____

Email Address _____

Phone Number _____

I authorize **Healthy Counseling Center** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

I authorize Healthy Counseling Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Visa ☐Mastercard

Credit Card Number _____

Expiration Date _____ Security Code _____

Billing Address _____

Phone number _____

SIGNATURE _____ DATE _____