A BRIEF COUNSELING CENTER
DBA: Healthy Counseling Center
9507 N. DIVISION STREET
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 Healthy 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 policies. 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 & Staff

HCC
Healthy Counseling Center

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: _____

Thank you for choosing Healthy 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.

Healthy 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. The initial intake appointment cost is $225.00 for one hour. Sessions are 45 minutes @ $135.00, and 53 minutes @ $150.00, unless we have made a mutual arrangement to adjust these fees.These appointments scheduled for you are set aside expressly for you, so we require 24 hours advance notice for cancellations. Appointments cancelled in less then 24 hours will be charged an $85.00 fee due prior to your next appointment. _____

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 to continue 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 Healthy 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 Healthy Counseling Center 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 Healthy Counseling Center to check my credit, employment, and insurance references.
- Assign all medical and or mental health benefits to be paid to Healthy 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 from services rendered or appointment times reserved and not kept (unless canceled 48 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 to continue to seek counseling. There will be a late fee of $30.00 on any payments received late. There will be 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 Healthy 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

HCC
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 Healthy 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. _____

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. _____

The law authorizes parent(s) or guardian(s) of a minor (anyone under age 18) to give informed 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 appointments. _____

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

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

   _____
   Signature (ages 13 to 17)

Welcome to our practice and thank you for choosing us.

Sincerely,

HCC
Healthy Counseling Center

Management & Staff