blue creek psychotherapy LLC

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Pottstown, PA 19464
610-850-0090
www.bluecreekpsychotherapy.com

Client Intake Face Sheet

Client name: _____ Date of birth: _____

Address: _____
(street)

_____, _____ _____
(city) (state) (zip)

Email address: _____

Home phone#: _____

Cell phone#: _____

Emergency contact name: _____ Relation: _____

Phone: _____

How did you hear about us? _____

Primary Insurance provider: _____

Insurance ID #: _____

Secondary Insurance provider: _____
(if applicable)
Insurance ID #: _____

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another identifiable person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or victim of physical, emotional or sexual abuse or neglect of a person under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. If a court of law issues a legitimate court order for information stated on the court order.

6. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name and only after I have consulted with you first.

If we see each other outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will acknowledge you in return, but feel it appropriate not to engage in any lengthy discussions in public/outside of the therapy office.

Minors and Consent for Treatment

If the client is under 14 years of age consent of both parents/guardians may be required to consent for treatment. This includes: 1) Cases where there is a shared custody agreement for divorced or separated parents, 2) Cases where the noncustodial parent retains medical rights or the right to participate in the medical decisions of the child, 3) Cases where no formal custody agreement exists, but the parents are divorced or separated.

Due to **Pennsylvania** law, if the client is between the ages of 14-17 years old, we require the client AND the parent(s)/guardian(s) sign consent forms for mental health treatment.

Client Signature_____ Date_____

Parent Signature_____ Date_____

Authorization to Release Information

_____ _____
Name of Client Date of Birth

I request and authorize **Blue Creek Psychotherapy** to receive and/or release healthcare information to:

Name:_____Phone number:_____

Address:_____

Description of information to be released: _____

_____

_____

I understand that I have no obligation whatsoever to disclose information from my client record, I do not have to sign this Authorization, and furthermore that my refusal to sign will not affect my ability to receive treatment from **Blue Creek Psychotherapy**, or my eligibility for benefits.

This Authorization expires one year from the date it was signed. I understand that I may revoke or cancel this Authorization at any time, by notification to **Blue Creek Psychotherapy** in writing, with exception to the extent that the agency has already acted upon it.

_____ _____
Client Signature Date

Emergency Contact Release Form

_____ _____

Name of Client Date of Birth

I give consent and authorize **Blue Creek Psychotherapy** to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name:_____

Telephone Number:_____

For the purpose of: Care during a medical or mental health (suicidal/homicidal) emergency.

The information authorized to be released (please check below):

_____ Any information related to a medical concern or emergency.

_____ Any information needed to secure safety when suicidal or homicidal.

I have been told that my records are confidential and information will not be shared except when required by law or when I have given my written permission. This release gives limited permission to contact the named person for the indicated purpose only. The release is effective until the time of discharge from services.

I understand that I may revoke or cancel this Authorization at any time, except to the extent that the agency has already acted upon it, by notification to **Blue Creek Psychotherapy** in writing.

I understand I am not required to sign this release in order to be treated at **Blue Creek Psychotherapy**. If I choose not to sign this release, I understand I am choosing instead for emergency professionals only to be called at 911 in the case of an emergency.

_____ _____

Client Signature Date

_____ _____

Parent Signature Date

Insurance Waiver Form

After reviewing my insurance benefits with **Blue Creek Psychotherapy** ("the provider"), I have elected NOT to utilize my insurance benefits. I agree to pay the agreed upon out-of-pocket fee and I understand that my insurance will not be billed and my fee will not go towards my deductible.

This authorization is valid from the date of myself or my representative's signature below and shall expire upon the date on which I deliver written notice of termination to the provider. This authorization may be canceled in writing at any time.

If I choose to utilize my insurance benefits in the future, I agree to deliver written notice of my request to my provider that will take in effect on the date that my notice is signed.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature_____Date_____

Office Policies

Appointments: The client (parent/legal guardian) and therapist mutually agree upon a scheduled appointment date and time. In the event or need to cancel or reschedule an appointment, please notify the therapist as soon as possible or 24 hours in advance of the appointment. No charges are incurred for cancellations made in advance of 24 hours prior to the appointment time. The therapist reserves the right to charge the person of financial responsibility for missed or late cancelled appointments, and also to close a case after repeated occurrences of such.

Fees for Services:

Masters-Level Therapist: Initial session (60 min.) $125-150
(LCSW,LPC,LMFT) Follow up sessions (45-50min) $100-130

PhD/PsyD-Level Therapist: Initial session $175

53-60 minute session $150

45-52 minute session $130

For all therapists: Consultation (including phone)/Report writing $25 (per 15 minutes)

Any missed/cancelled appointment without 24 hours notice (M-F) will be assessed a $65 fee.

(Sat.) $75

We reserve the right to charge $30 for any returned check.

Health Insurance/Fees/Billing: Many insurances are accepted by the provider. However, it is up to the client (or financially responsible party) to be aware and informed of the terms of the specific plan(s) being offered, and to be prepared to provide any and all information that is necessary for the timely filing of insurance claims. Co-payments and/or coinsurance are contractually agreed upon by the member or policy holder and must be collected by the provider at the time the service is rendered. Each client (or financially responsible party) is ultimately responsible for the payment of service fees. For unpaid balances that are not collected, the credit card on file will be charged. The therapist reserves the right to suspend delivery of treatment if the client's balance is unpaid.

If we are in network with your insurance, we will file any claims on your behalf. If we are out of network with your insurance, we will provide a detailed receipt (“superbill”) so you can submit it to your insurance company for possible reimbursement. We do not file claims for "secondary insurances" only for primary insurance.

Emergencies: The nature of private practice outpatient psychotherapy at times may mean that the therapist will not be easily available. In the event of a mental health or medical emergency please do not wait for the provider. The client (or parent/legal guardian) should contact Crisis Intervention (Montgomery County 1-855-634-4673), call 911, or go to the nearest emergency room for care and treatment.

Social Media Policy: We use various social media platforms to advertise our practice. In order to protect your confidentiality, we will not interact with you in any way on **Blue Creek Psychotherapy** social media pages. As a matter of ethics, we also do not interact with clients in any manner if the therapist has a personal social media account. Thank you for helping us protect your confidentiality and maintain good therapist/client boundaries.

Litigation Limitation: Due to the nature of the therapeutic process and that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, you agree that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), either you (client) nor anyone else acting on your behalf will call on the therapist to testify in court or at any other proceeding. However, if an appearance at court on your behalf is required by law and you have signed a release form allowing this, the fee is $800 per day, $400 ½ day to reserve the therapist's time and must be paid in full 14 days prior to the expected court date.

Credit Card on File: I agree to keep a credit card on file so that it can be charged for the following: 1) Late Cancellation/No Show Fee, 2) Insurance refusal to pay for services, 3) Balances that have not been paid at the time of the appointment.

Client Signature_____ Date_____

Parent Signature_____ Date_____

Credit Card Authorization Form

Please complete the following information.

I,_____, authorize **Blue Creek Psychotherapy LLC** to charge my credit/debit card ending in _____(last 4 digits) on file for professional services as follows:

Please initial:

_____Any balances that are not paid at the time of service.

_____Missed/Cancelled appointments with less than 24 hours notice.

_____Appointments that are missed without notice, “no show.”

_____Insurance refusal to pay for services, resulting in a balance.

I agree that:

_____If I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my counselor with Blue Creek Psychotherapy LLC for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my counselor and those attempts have failed. In the event of discussing charges with credit card company, I authorize Blue Creek Psychotherapy LLC to disclose my appointment correspondence and fees to my credit card company.

This form may be updated upon request at any time. This authorization is valid until my treatment ends unless I cancel this authorization in writing.

_____

Signature of Financially Responsible Party Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET

ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed.

However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of
2. such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws. 10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and

disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Client Signature_____ Date_____

Parent Signature_____ Date_____