

Client Information

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

DATE OF BIRTH: _____

AGE: _____

YRS OF EDUCATION: _____

MARITAL STATUS: _____

HOME PHONE # _____ MAY WE CALL YOU AT HOME? ___ YES ___ NO

MAY WE LEAVE MESSAGE AT WORK? ___ YES ___ NO

WORK PHONE# _____ MAY WE CALL YOU AT WORK? ___ YES ___ NO

MAY WE LEAVE MESSAGE AT WORK? ___ YES ___ NO

PAGER/CELL#: _____

MAY WE CALL OR LEAVE MESSAGE ON CELL? ___ YES ___ NO

EMAIL ADDRESS: _____

MAY WE CONTACT YOU THROUGH EMAIL? ___ YES ___ NO

PARENT EMAIL #1: _____

PARENT EMAIL #2: _____

EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

Informed Consent for Counseling/Consulting

I request and voluntarily consent to performance consulting/counseling/therapy for myself or son or daughter who is a minor. My informed consent for performance consulting/counseling/therapy ends with my termination from Athletic Mind Institute, LLC.. I understand that I may terminate performance consulting/counseling/therapy for myself or son/daughter and this consent at any time.

Name of Client: _____
Signature of Client: _____
Date: _____

Name of Parent or Guardian: _____
Signature of Parent or Guardian: _____
Date: _____

Scheduling and Missed Appointment Policy

Athletic Mind Institute, Ltd. makes every effort to schedule appointments that are convenient and timely. Since demand for our services often exceeds available staff time, we have adopted the following policy to provide service to as many people as possible.

- (1) If you need to reschedule or cancel an appointment, please notify us **at least 24 hours in advance** by calling (614) 874-0178.
- (2) If you do not cancel your appointment within 24 hours before your appointment time, you will be charged the full cost of the session. Your insurance company cannot be billed and is not responsible for the cost of a missed appointment. You will be responsible for the cost of covering the missed appointment, not the insurance company.

Your assistance in keeping scheduled appointments is greatly appreciated as we strive to meet your needs and those of other people.

I have read and understand the missed appointment policy.

_____ Client Signature	_____ Date
_____ Parent or Guardian Signature	_____ Date
_____ Witness	_____ Date

Consent to use and disclose your health information and confidentiality

This form is an agreement between you and me/us Athletic Mind Institute, LLC. When we use the word “you” below, it can mean you, your child, a relative, or other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 614-874-0178 from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Client Name (Please Print)

Client Signature

Date

Confidentiality

The contents of a counseling, intake or assessment session are considered to be confidential. In general, both verbal information and written records about a patient cannot be shared with another party without the consent of the patient or the patient's legal guardian. IT NEEDS TO BE NOTED HOWEVER THAT PSYCHOLOGICAL INFORMATION MAY BECOME PART OF THE MEDICAL RECORDS AND THEREFORE CAN BE INCLUDED IN MEDICAL RECORDS THAT ARE REQUESTED BY OUTSIDE PARTIES (i.e., primary care physician, legal office or attorney, etc.). By signing this statement, you are giving consent for your psychological information to be included in the medical information requested by and sent to other parties. This is necessary in order for the entire medical team to be aware of any psychological issues impacting medical treatment. Furthermore, additional exceptions to confidentiality are as follows:

Duty to warn and protect:

When a patient discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and vulnerable adults:

If a patient states or suggests that he or she is abusing a child (or vulnerable adult), has recently abused a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal exposure to controlled substances:

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the event of a patient's death:

In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their child's or spouse's records.

Professional misconduct:

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Drug Use:

If a patient is using any illicit drugs (ex. marijuana, cocaine), alcohol, and/or non-prescribed medications, the behavioral health team may disclose this information to the medical staff at Pain Control Consultants.

Court orders:

Health care professionals are required to release records of patients when a court order has been placed.

Minor/guardianship:

Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records.

Other Provisions of confidentiality

Insurance companies and other third party payers are given information they request regarding services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries.

Information about patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the patient, or any identifying information, is not disclosed. Clinical information about the patient is discussed.

In some case notes and reports that are dictated/typed with in the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups or families are receiving services, separate files are kept for individuals for information disclosed which is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professionals which was not in the presence of the other person(s) utilizing services, (c) information received from other sources about the patient, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (g) information which has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) are not disclosed. If a debt remains unpaid, it may be reported to credit agencies and the patient's credit report may state the amount owed a timeframe and the name of the clinic.

In the event in which the clinic or mental health professional must phone the patient for purposes such as appointment cancellations, reminders or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like to identify ourselves. One example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather, the mental health professional's first name only.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Name (Please Print)

Client Signature

Date

Fees and Financial Policy

<u>Individual Counseling</u>		Fees
Initial Consultation	\$200.00	90 minutes
Individual Session	\$150.00	60 minutes
Telephone Consultation	\$125.00	60 minutes (billed in 15 minute increments)
Email Consultation	\$125.00	60 minutes (billed in 15 minute increments)
Written Correspondence	\$125.00	60 minutes (billed in 15 minute increments)

Our policy is to expect payment at the time of service. For those plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment. Your insurance policy is a contract between you and your insurance company, to which we are not a party. With the increased complexity in this area, we ask you to assume responsibility of understanding and advising us of the terms of your policy regarding mental health treatment, including the following:

- Whether we are a recognized provider or if the policy pays out of network providers.
- The status of your yearly deductible.
- The amount of co-pays, if any.
- Your policy limits for mental health treatment.

We cannot bill your insurance company unless we have accurate insurance information and an original claim form with your portion filled out and properly signed. Unusual circumstances or situations must be discussed directly with us.

Minors

The adult accompanying a minor (parent or other party) is responsible for 100% payment at the time of service.

Missed Appointments

Unless cancelled 24 hours in advance, our policy is to charge for missed appointments at the rate of 100% of our normal fee. Please help us serve you better by keeping scheduled appointments.

Payments and Delinquent Accounts

I understand that payments are due at time of service. I understand that any unpaid balance remaining on my account including those remaining after insurance and applicable co-pays is my responsibility and I agree to pay this balance. I understand that if I am unable to pay the full balance due in a timely manner (within 30 days of the billing date or as otherwise arranged with Athletic Mind Institute) that I must contact Athletic Mind Institute. I understand that if I refuse or fail to pay my outstanding bill and/or have made no "good faith" payments for a period of at least thirty days after the billing date, that my account may be assessed a late fee of \$25 per month and/or be subject to referral to a third party for collection. I understand that this policy is necessary to ensure quality services are available to all clients of Athletic Mind Institute.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Fees and Financial Policy. I understand and agree with the Fees and Financial Policy.

X _____ Date _____
 Signature of Client or Responsible Party