Today's Date:

Name: (First, Last) _____
Nickname: _____ If minor, parent/guardian name(s):
_____
Sex: _____ DOB: _____ Age: _____ Ethnicity: _____ SS#: _____ Address:
_____
_____ City: _____
State: _____ ZIP: _____ Phone: _____ (home) _____ (cell) _____ (other: _____) Email Address:
_____
_____ (please print) # of Children _____ Marital Status: ▫Married ▫Divorced ▫Separated ▫Widowed ▫Single Education: ▫Grade School ▫Some High School ▫High School/GED ▫Some College

▫College Graduate ▫Master's Degree ▫Doctoral Degree
Emergency Contact: _____ Phone: _____ Relationship: _____ Employment: ▫ Employed ▫Unemployed ▫ Full-Time Student ▫ Part-Time Student

▫ Disabled ▫Retired
Insurance Company: _____ Insured's Name _____ Relationship to patient: _____ Insured's DOB: _____ ID#: _____ Claims Address: _____ Phone #: _____ Insurance Plan/Program: _____ Policy Group: _____

Referred by: _____
Previous Counseling? _____ If yes, when? _____
Where? _____ How long? _____
Why?
_____
_____ Current reason for seeking counseling:
_____

Follow-up: Healing Mind Space **does / does not** have my permission to call/email me for follow-up contact after my last appointment. _____ (INITIAL)

Best way to contact for follow-up: ▫Phone ▫Email ▫Other: _____

Your signature below indicates you have read and agree to the following:

CONSENT FOR TREATMENT

I give permission to Healing Mind Space Counseling and Education to provide outpatient mental health services to my child or myself. I am aware that my therapist is available to answer questions about my counseling or about this form.

FINANCIAL RESPONSIBILITY

I understand and agree to take full responsibility for the fees for services rendered. I agree that payments are due at the time of the appointment. Missed appointment charges (any appointment cancelled with less than 24 hours' notice). The initial evaluation is billed at $160.00 and each subsequent 50-minute session is billed at $125.00. The fee for missed appointments is $100.00. A fee of $50.00 will be charged for any letters that are requested by me regarding treatment with my therapist. A $35.00 fee will be charged for any checks returned by my bank.

If I become involved in court proceedings that require my therapist's time, I will be expected to pay for professional services in advance at the rate of $250.00 per hour for preparation of reports. In the event that I request my therapist to appear for court to provide testimony, I will be charged in four-hour increments at the rate of $250.00/hour. This payment is due prior to the court date. If my therapist is present for court more than four hours, I will be billed and responsible for payment of his/her time at the rate of $250.00/hour. Services related to court proceedings include, but are not limited to, report writing, telephone calls, court/deposition appearances, and travel time.

My account shall be in default if my unpaid balance is 30 days past due. In the event that Healing Mind Space, in its sole discretion, forwards my account to a collection firm, I agree to pay all costs associated with the collection. In the event that legal action is initiated, I agree to pay reasonable attorney's fees, costs and interest at 10% annum on any unpaid balances. I agree that all litigation arising out of this agreement shall be decided in the Courts of the County of Providence Plantations.

NOTICE OF PRIVACY POLICIES

I acknowledge that I have been offered a copy of the "HIPAA Consent Form – Privacy Policies" and understand the information that is included in this document. I am aware that a copy of this notice will be given to me when I ask for a copy.

Signature_____
Date: _____ Printed Name: _____ Relationship to Patient: _____

HIPAA CONSENT FORM – PRIVACY POLICIES

The Health Insurance Portability Act of 1996 (HIPAA) states that all individuals receiving Medical or Mental Health treatment have a right to their privacy and, therefore, a right to protect the privacy of their records:

§164.506 Uses and disclosures to carry out treatment, payment, or health care operations.
(a) ***Standard: Permitted uses and disclosures.*** *Except with respect to uses or disclosures that require an authorization under §164.508(a)(2) through (4) or that are prohibited under §164.502(a)(5)(i), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.*
(b) ***Standard: Consent for uses and disclosures permitted.***
(1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.
(2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under §164.508, is required or when another condition must be met for such

use or disclosure to be permissible under this subpart.
(c) ***Implementation specifications: Treatment, payment, or health care operations.***
(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.
(2) A covered entity may disclose protected health information for treatment activities of a health care provider.
(3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.
(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:
(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or
(ii) For the purpose of health care fraud and abuse detection or compliance.
(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to other participants in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

Healing Mind Space will keep all information private with the following exceptions:

1. If there is a report of neglect of a child or vulnerable adult. By law we are required to report this information.

2. Release information to your insurance company for billing.

3. When you (as the patient) or your legal guardian signs a Release of Information Form giving HMS permission to forward clinical information to an outside agency (school, doctor, lawyer, etc.)

For individuals participating in Group Therapy: Participants are not allowed to disclose the name or any other identifying information of fellow group members. Participants are also not allowed to disclose any personal or confidential information pertaining to fellow group members.

By signing this document, you accept the terms listed above and give Healing Mind Space consent to provide the necessary information to your insurance company and allow Healing Mind Space to bill for services. You also understand that if there is a report of abuse toward a child or vulnerable adult that has not already been reported, your therapist is obligated to do so.

Client Signature: _____ Date: _____ Client Printed Name: _____

_____ Guardian Signature (if applicable)

_____

HMS Representative: _____

_____