missoula MINDFUL counseling

NEW PATIENT INFORMATION

Client Information		Financially Responsible Person (if different)	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Home phone #		Home phone #	
Work phone #		Work phone #	
Cell phone #		Cell phone #	
Social security #		Social security #	
Birth date		Relationship to client	
Age		Employer	
Ethnicity		**Insurance Information**	
Relationship status		Insurance company name	
Employer		Address to mail claims	
Occupation		City/State/Zip	
Primary care physician		Phone #	
Psychiatrist		Policy holder's name (if different)	
How did you hear about me?		Policy holder's SS#	
Emergency Contact		Policy holder's birth date	
Name		Policy #	

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Relationship to client		Group #	
Phone #		Date form completed	

Name: Date of Birth: Date Form Completed:

MEDICATION LOG

Medication	Prescribing physician	Why prescribed	Dosage

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PRACTICE POLICIES

I am pleased to welcome you to my therapy practice, Missoula Mindful Counseling. This document contains important information about how I run my practice, and once you sign it, it serves as a contract between us. Please read it carefully and jot down any questions you have so we can discuss them.

Counseling Services

Counseling is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring in. There are many approaches to therapy, and together you and I will decide which will work best for you. One thing you can count on is that you will play a very active role in your therapy, helping to set our direction in each session and working on your own between sessions.

Counseling can have benefits but also risks, about which you need to be informed. Because it often involves discussing painful aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, or helplessness. Typically, however, therapy results in benefits such as improved relationships, solutions to specific problems, and specific reductions in feelings of distress. But there are no guarantees of what you will experience.

Sessions

I usually schedule one 55-minute appointment per week, although length and frequency of sessions may vary. Our first session will be billed as a "diagnostic interview," and our first few sessions will be devoted to getting to know each other and evaluating what you need and whether I can help you. During this time, we can both decide if we are a good match. Once therapy is begun, clients usually end treatment once they feel their goals have been met. I depend on your feedback to be the most effective therapist for you, and I invite you to raise questions about your progress and therapy termination at any point. I also appreciate it when clients tell me what they find helpful and what is ineffective.

Contacting Me

The best way to contact me is by phone, text or email. As there is no way to guarantee the confidentiality of email, sensitive or time sensitive information should be communicated over the phone. These forms of communication are not appropriate for therapeutic issues which will be discussed in session only. If you are having a mental health crisis or emergency and I am not available, contact your physician or the nearest emergency room and ask for the Mental Health Professional on call.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they contain a lot of jargon that is specific to psychology; they can be easily misinterpreted or upsetting to untrained readers. Thus if you wish to see your records, I recommend that you review them in my presence so that I can answer your questions. I may charge a copying fee. Please see the HIPAA notice for more information.

(*continued)*

Confidentiality

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings, however, such as those involving child custody or those in which your emotional condition is an important issue, a judge may order my testimony.

There are some situations in which I am legally obligated to take action to protect others from harm, even if it means I have to break confidentiality. For example, if I believe that a child or a vulnerable adult is being abused, I must file a report with the appropriate state agency, which may mean I have to reveal some information about a client's treatment.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions—including notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client is at high risk of suicide or serious self-harm, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If such a situation does arise during our work together, I will make every effort to fully discuss it with you before taking any action, and I will disclose the least amount of information possible.

I may occasionally consult with other professionals about a case. During a consultation, I do not disclose the identity of my client, unless you have given me a release to do so. The consultant is also legally bound to keep the information confidential. If you don't object, I won't tell you about these consultations unless I feel it is important in our work together.

Finally, I need to disclose some information to your insurance company or other third party payer in order to bill and collect payment. Typically, I only disclose session date and length, procedure code, and diagnosis. At times, third party payers request more detailed information; in this case, I will make every effort to review with you the information to be disclosed before I release it. As with the other situations above, I always disclose the least amount of information possible.

Minors

If you are under 18 years old, the law may give your parents/guardians the right to examine your treatment records. It is my policy to ask that parents respect your confidentiality and not request access to your records. If they agree to this, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will do my best to discuss it with you before giving them any information.

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FINANCIAL POLICY

Fees and Payment Options: You may pay your out-of-pocket costs at the time of service by check, credit card or cash.

Service	Fee	CPT Code
15 minute consultation	free	
First session (diagnostic interview; 1 hour)	$170	90791
Subsequent 53-60 minute sessions	$155	90837
Shorter sessions (38- 52 minutes)	$120	90834

Insurance Coverage: Many insurance companies require pre-authorization and/or referral prior to obtaining specialty care. It is your responsibility to contact your insurer to determine the need for a referral and/or pre-authorization. Failure to obtain the referral and/or preauthorization may result in lower payment or claim denial from the insurance company.

I am a provider for, Blue Cross/Blue Shield, Pacific Source, Montana Health Co-op, Cigna, Allegiance, Medicaid and others.

Please bring your insurance card with you to your first appointment as well as your co-pay.

I collect copays at the time of service. If you do not know what your copay is, please call your insurance company to find out. You can provide them the relevant CPT codes listed above.

Worker's Compensation Clients: Please bring the name, address and phone number of your worker's comp carrier as well as the claim number assigned to your case.

Motor Vehicle Accident/Legal Claim Clients: MVA patients and other clients whose therapy is paid for by a legal settlement are ultimately self-pay. I will provide you with a statement that you can submit to your carrier/attorney.

Past Due Accounts: For unpaid balances, you will be billed monthly. I do not make appointments with clients who have more than a $500 balance, until payment arrangements are made.

If at any time you have a balance due which is more than 30 days old and have not made appropriate payment arrangements with me, or if you have established a payment plan and you default on the agreed upon plan, a suit may be brought in court, and the prevailing party may, in the discretion of the court, be entitled to recover all costs, including reasonable attorney fees, costs of court, service of process fees, and levying fees. Further, any unpaid balance or damages owed may be placed with a third party collection agency either before or after a suit is brought, or in the absence of a suit. In the event any amount is placed for collection with any third party collection agency, the fee charged by the agency may be added to the total amount due and shall be in addition to any other costs (such as court costs and attorney fees—including attorneys' fees incurred by either party or the agency), incurred directly or indirectly to collect amounts owed. In any of these events, the fact that you received treatment at our office may become a matter of public record.

Returned Check Fee: In addition to amounts your bank may charge you, I may charge $30 for any returned/ dishonored check as well as any other statutory penalty allowed by law.

Missed Appointment Fee: The first time that a client misses or cancels an appointment without adequate notice they get a "free pass." The second time and subsequent times a client does not show up for an appointment, or cancels with less than 24 hours notice, a missed appointment fee of $ 110 will be automatically charged. Clients who chronically miss appointments may be asked to transfer their records to another provider.

Effective Date: Once you have signed our contract, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

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HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical information is private and confidential. I am required by law to maintain the privacy of "protected health information" (PHI). PHI includes all information that can be identified as yours. I must provide you with this notice about my privacy practices that explain how, when and why I use and disclose your PHI and must comply with these policies. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the disclosure.

I reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to existing PHI. If I make an important change to our policies, I will change this notice and post a new notice in the waiting area. You can request a copy of this notice at any time.

PERMITTED USES AND DISCLOSURES

I can use or disclose your PHI for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, I have provided a description and an example below. However, not every particular use or disclosure in every category is listed.

> ***Treatment****:* I may disclose your PHI to physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, I might alert a physician when a client's antidepressants are not working as well as expected.
>
> ***Payment:*** I may use and disclose your PHI in order to bill and collect payment for treatment and services provided to you. For example, your insurance may require clarification of the treatment given in order to determine the level of benefits available for that visit.
>
> ***Health care operations:*** I may disclose your PHI in order to operate this practice. For example, activities related to quality assurance, case management, receiving and responding to patient comments, and business planning may require the use of PHI.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, I may use your PHI in the following ways:

- I may contact you to provide appointment reminders.
- I may contact you to tell you about or recommend possible treatment alternatives or other health- related benefits and services that may be of interest to you.
- I may disclose to your family and friends or any other individual PHI directly relevant to such person's involvement with your care or payment for your care, unless you object.
- Subject to applicable law, I may make incidental uses and disclosures of PHI. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION

Request Limits on the Uses and Disclosures of Your PHI: You have the right to ask that I limit how I use and disclose your PHI. Requests to limit the use and disclosure to your PHI must be submitted in writing. I will consider your request but am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

Right to See and Get Copies of your PHI: In most cases, you have the right to look at or get copies of your PHI, but you must make the request in writing. Further, you have the right to ask that I send information to you to an alternative address or by alternative means. I must agree to your request so long as I can easily provide it in the format you requested. If I do not, I will tell you, in writing, my reasons for the denial and explain your right to have the denial reviewed. There may be charges for copies made.

Right to Get a List of Disclosures I Have Made: You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that are made for treatment, payment, health care operations, national security purposes, to corrections or law enforcement personnel or pursuant to your authorizations. To request a list of disclosures of your PHI, you must submit your request in writing, including a specific time period for the accounting (e.g., the past three months).

Right to Correct or Update your PHI: If you believe there is a mistake in your PHI or that a piece of information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request. I may deny the request if the PHI is not correct and complete, not created by me, not allowed to be disclosed, or not part of my record. My written denial will state the reasons for the denial and explain my right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

COMPLAINTS ABOUT PRIVACY PRACTICES

If you think your privacy rights have been violated, you should immediately contact me or file a complaint with the Montana Secretary of Health and Human Services. I will not take action against you for filing a complaint.

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CONTRACT

This contract establishes our agreement to the various policies outlined in the New Patient Packet. Your initials and signature indicate that you have read the information provided and agree to abide by the Practice Policies, the Financial Policy, and the HIPAA Privacy Notice.

1. I have read the Practice Policies and agree to abide by their terms. **Initials:** _____
2. I have read the Financial Policy and agree to abide by its terms. **Initials:** _____
3. I have been provided a copy of the HIPAA Privacy Notice. **Initials:** _____
4. Assignment and Release: I acknowledge that Greg Shanks, LCPC may release to third party payers requested medical and/or other information necessary to process my claim(s). I recognize that this information may include medical, psychological and psychiatric information and diagnosis. I hereby assign to Greg Shanks, DBA Missoula Mindful Counseling, (MMC) all benefits which are or shall become payable from any third party payer who is responsible for payment of my charges. I authorize and direct all third party payers to pay all benefits directly to Greg Shanks/MMC. **Initials:** _____

Patient and/or persons legally and financially responsible for patient's medical bills agree to pay patient's account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Greg Shanks/MMC is free to declare the entire balance to be due and payable if any scheduled payments are missed.

If at any time a balance due is more than 30 days old and appropriate payment arrangements have not been made, or the agreed upon payment plan is defaulted on, a suit may be brought in court, and the prevailing party may, in the discretion of the court, be entitled to recover all costs, including reasonable attorney fees, costs of court, service of process fees, and levying fees. Further, any unpaid balance or damages owed may be placed with a third party collection agency either before or after a suit is brought, or in the absence of a suit. In the event any amount is placed for collection with any third party collection agency, the fee charged by the agency may be added to the total amount due and shall be in addition to any other costs (such as court costs and attorney fees—including attorneys' fees incurred by either party or the agency), incurred directly or indirectly to collect amounts owed.

I agree to pay all costs of collection, including fees described above, if the account is not paid on time. **Initials:** _____

I authorize treatment of the person named below and agree to pay all fees and charges for any services. **Initials:** _____

_____	_____	_____ _____
Client Name (printed)	Client Date of Birth	Client Signature Date

_____	_____	_____
Parent/Guardian Name (printed)	Parent/Guardian Signature	Date