Advantage Counseling Services **Client Demographic Information**

Name:	DOB:
Address:	City:
Zip:	Phone/ Mobile:
Email:	Insurance Provider:
Email:	Insurance Provider:
Marital/ Relationship Status:	Employment Status/ Employer:

Advantage Counseling Services LLC HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Effective Date March 18, 2019/ Updated May 2, 2020.

This notice serves as Advantage Counseling Services LLC policy related to the use and disclosure of your healthcare information.

Advantage Counseling LLC will only release information in accordance with state and federal laws and the ethics of the counseling profession. This includes any protected health information and substance use information.

This practice uses and discloses protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. The following are examples of how you protected health information may be used:

TREATMENT Use and disclose health information to: • Provide, manage or coordinate care • Consultants • Referral sources
PAYMENT Use and disclose health information to: • Verify insurance and coverage • Process claims and collect fees
HEALTHCARE OPERATIONS Use and disclose health information for: • Review of treatment procedures • Review of business activities • Certification • Staff training • Compliance and licensing activities
OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT • Mandated reporting • Emergencies • Criminal damage • Appointment scheduling • Treatment alternatives • As required by law

CLIENT RIGHTS

RIGHT TO REQUEST WHERE WE CONTACT YOU • Preferred contact method:	**RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTHCARE INFORMATION** • Must be in writing • You are not obligated to agree
RIGHT TO RELEASE YOUR MEDICAL RECORDS • Written authorization to release records to others • Right to revoke release in writing • Revocation is not valid to the extent that you have acted in reliance on such previous authorization	**RIGHT TO COMPLAIN** • Please discuss any concerns with me so we can attempt to resolve them • If not satisfied, right to complain to the U.S. Dept. of Health and Human Services • No retaliation
RIGHT TO INSPECT AND COPY YOUR MEDICAL BILLING RECORDS • Right to inspect and copy records • Counselor may deny this request • Charges for copying, mailing, etc.	**RIGHT TO RECEIVE CHANGES IN POLICY** • May request any future changes
RIGHT TO ADD INFORMATION OR AMEND YOUR MEDICAL RECORDS • May request to amend record • Number of days to decide • May deny the request • If denied, right to file disagreement statement • Disagreement state and your response will be filled in the record • Amendment request must be in writing	**RIGHT TO ACCOUNTING OF DISCLOSURES** For a six year period beginning (with 3/18/2019) Exceptions: • Disclosure for treatment, payment or healthcare operations • Disclosures pursuant to a signed release • Disclosure made to client • Disclosures for national security or law enforcement

Client Signature:_____ Date: _____

Advantage Counseling Services LLC Fees/Payment/Cancellation/Freedom to Choose

Individual Therapy:+
Initial Evaluation Session $150
50-60 Minute Sessions $140
Sliding scale fees and flat fee for service plans available for qualifying clients +

Couples/Marital Therapy:+
Initial Evaluation Session $150
60-90 Minute Sessions $140
Sliding scale fees and flat fee for service plans available for qualifying clients +

Court Ordered Services (not billed to insurance): +
Court/Employer Ordered Substance Use Disorder Evaluations $150 per evaluation

VASAP Treatment Assessments $80 per assessment

SAP Evaluations/ Case Management $450

+For clients paying flat fees for services, payment is expected at the time of session.

Payment:
You will be expected to pay for either each session in full, or your insurance co-payment at the time of your appointment. Accepted methods of payment are cash or credit/ debit card. There is an additional $3 charge to process credit card payments.

Secondary Insurance:
I do not bill secondary insurance. You are expected to pay the difference in the amount paid by your primary insurance carrier and their contracted rate for services. Upon request, I will provide you with a copy of the adjusted claim once the primary insurance has processed your claim.

+++ Sliding Fee Qualifying Incomes
Clients wishing to apply for the sliding scale fees need to bring their last year's tax returns to the first session.

$6,245.00 - $21,330.00 = $35 per session
$21,331.00 - 30,170.00 = $45 per session
$30,171.00 - $39,010.00 = $55 per session
$39,011.00 - $52,270.00 = $65 per session

Client Signature/ Date:

Freedom to Choose Form (Medicaid Clients Only)

I understand that I have a choice in whom I choose to see for individual or group therapy. By signing below, I acknowledge this choice and indicate that I am choosing Advantage Counseling Services, LLC to provide my counseling services.

Client Signature: _____ Date: _____

Advantage Counseling Services, LLC
Missed Appointment & Payment of Fees Policy

Missed Appointment/ Late Cancellations

Your appointment time is reserved just for you. Due to this, if you are unable to attend an appointment, I require that you provide at least 24 hours advanced notice. ***Failure to provide 24 hours' notice for canceled appointments or missed appointments will result in a fee of $45 dollars.***

Late cancelation/ missed appointment fees are not paid by insurance or EAP's and are billed directly to you.

To prevent the necessity of using a fee recovery service, all clients are required to provide either a credit or debit card, which will remain on file, to be used for payment of any late cancelation fees or outstanding balances. This information will remain secured and confidential, with this form being destroyed once your payment information is entered into the electronic health record.

Credit Card Payment Information Form

By signing below, you are acknowledging that you have read the missed appointments and payments of fees policy. Your signature also authorizes Advantage Counseling Services, LLC to apply payment to your card for late cancelations/missed appointments, and outstanding balances.

ALL CLIENTS COMPLETE THIS FORM

Name on Card:

Credit Card #:

Expiration Date:

CVV Code on Back of Card:

Billing Zip Code:

Client Signature: _____ **Date:** _____

Advantage Counseling Services, LLC Telebehavioral Health Informed Consent

Please review each statement and check the corresponding box signifying your acknowledgement and agreement with each statement.

Introduction of Telebehavioral Health:

☐Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

Software Security Protocols:

☐Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

☐This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

☐I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. I will be given a basic instruction sheet.

Risks of Technology:

☐These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

☐My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies, and modify our plan as needed.

Client Communication:

☐It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications. I am giving Advantage Counseling Services, LLC permission to bill my insurance company for these services.

Laws & Standards:

☐The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Laws & Standards:

☐The same limits of confidentiality that apply to face-to-face sessions also apply to telebehavioral health sessions. **It is up to the client, to ensure that their session location is in a confidential, quiet setting on their end. Sessions with small children present, in stores, places of business, or cars with other people are not a suitable setting for therapy.**

Confirmation of Agreement:

Client Signature: _____ Date: _____

(Client Signature indicates Consent To Treat/ Bill Client's Insurance For Telebehavioral Health Services)

Advantage Counseling Services, LLC Consent for Treatment and Limits of Liability

Please review each statement and check (X) the corresponding box signifying your acknowledgement and agreement with each statement.

Limits of Services and Assumption of Risks:

☐Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

☐What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian.

THE FOLLOWING IS A LIST OF EXCEPTIONS

Duty to Warn and Protect:

☐If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan or threat to harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults:

☐If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances:

☐Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Guardianship:

☐ Legal guardians have the right to access the clients' records.

Insurance Providers:

☐Insurance companies and other third-party payers are given information that they request regarding services to clients in order to process your claim. The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc. ***By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications. I also give permission for Advantage Counseling Services to bill my insurance/ EAP service and provide any needed information to assure accurate billing.***

EMERGENCY / AFTER HOURS PRECEDURES

☐My normal business hours are 9:00am-6:00pm Wednesday-Friday. I can respond to email/ text on a limited basis on Monday/ Tuesday. My direct number is 540-836-3659.

If you should have a mental health emergency after my business hours, please contact:

- **Either Emergency Services at Valley Community Services Board at 540-885-0866, 540-943-1590, or toll free 866-274-7475;**
- **Or go to Augusta Health Emergency Room.**

Client Signature: _____ Date: _____