Client Registration

Name _____ Age _____ Gender_____

Home Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security # _____

Parent/Guardian (if applicable) _____

CONTACT INFORMATION:

Home _____ Work _____ Cell _____

Email (optional) _____

Emergency Contact Info _____

INSURANCE (if applicable)

Insurance Carrier _____ Phone _____

ID Number _____ Group # _____

Insured Name _____Relationship _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Employer _____

By signing below, I affirm that I understand the basic ideas, goals, and methods of this therapy. With enough knowledge, and without being forced, I enter into treatment. The therapist has addressed my questions and/or concerns regarding confidentiality and the therapy process. I understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this therapist's willingness to use and share his or her knowledge and skills in good faith. Periodically during treatment, we will evaluate progress and may change treatment goals as needed. If it becomes clear that there is a need to transition care to another therapist for any reason (e.g., the nature of symptoms being addressed, misfit of personality, lack of progress etc.) I agree to discuss these concerns with my therapist and to participate in planning for transition to a new therapist if the issues cannot be resolved.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party.

I understand that 24-hour notice is required for the cancellation of a session. If 24-hour notice is not given, I understand that I may be responsible for a fee of $130, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.

By signing below you are consenting to receiving the psychotherapy services of PeoplePsych, LLC.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Fees & Insurance

PeoplePsych's standard therapy sessions (for individual, couple, and family sessions) are 60 minutes in length and fees are as follows:

- Initial Session - $160.00
- Subsequent Sessions - $130.00

All client fees are due at time of service. Payment may be made by cash, check, PayPal or credit/debit card.

In some cases, fee for service clients may negotiate a lower rate for sessions by first speaking with their therapist who will discuss the request with the PeoplePsych billing department.

Longer sessions are available upon request and will result in an additional fee. Insurance may not cover longer sessions.

We require 24 hours notice of any cancellation. Clients may otherwise be charged the full session fee. Insurance does not cover missed sessions.

Please note that you are responsible for all deductibles and co-pays as determined by your insurance plan.

Rates may increase periodically; clients will be informed prior to any rate change.

Insurance Information

For those wishing to use insurance, please note that PeoplePsych:

1. Therapists are in-network for Blue Cross Blue Shield (BCBS) PPO and Blue Choice plans only.
2. Will attempt to access out-of-network coverage for those covered by other PPO plans.
3. Will *not* access any HMO or similar plan for coverage, including BCBS HMO plans.

For those covered by BCBS PPO and Blue Choice plans, PeoplePsych therapists have agreed to the usual and customary rate deemed appropriate by the insurance company. PeoplePsych only charges these clients the charges related to the deductible and the co-pay (or co-insurance) as determined by BCBS.

PeoplePsych will verify eligibility and benefits for all PPO clients. Clients/responsible party will be notified of expected charges as soon as possible. Please note that the outstanding deductible is generally not known until each claim is processed by the insurance company, PeoplePsych will notify clients of any balance due as soon as possible.

For those clients accessing <u>out-of-network insurance coverage</u>:

1. PeoplePsych may request that clients pay the balance due in full, if the carrier does not process the claims in a timely manner (30 days).
2. In the event that the carrier is known to lag in the processing of out-of-network claims, clients may be asked to pay for sessions in full.
3. Any overpayment of monies by client will be refunded in full by PeoplePsych's billing department.

Verification of benefits or coverage is not a guarantee of eligibility or payment. Actual payment is based upon plan provisions and limitations in affect on the specific Date of the Service. All claims are subject to review upon receipt of the Insurance Payer. Insurance companies reserve the right to refuse payment, clients can appeal to the insurance company for any denial of payment. In the event no payment is made, clients are ultimately responsible for the full fee.

By signing below, I certify that I understand and accept the terms described above.

Signature of Responsible Party: _____Date:_____

Insurance Release of Information

I hereby authorize PeoplePsych, LLC to release any of the following requested information to my insurance company for the purpose of obtaining reimbursement for services.

Please initial each pertinent section and sign below

_____ Information may include:

- Clinical Diagnosis
- Dates of Service
- Clinical Assessment
- Summary of Services
- Designated clinical records (e.g., treatment plans, progress notes, test results, etc.)

_____ Information may be released to any or all of the following as needed:

- PeoplePsych's contracted billing service
- Any third party payer having responsibility for payment of charges for treatment
- Review agents/auditors
- Managed Care agents

_____ This consent is valid until such time that all claims have been settled to the satisfaction of PeoplePsych, LLC or up to one year from the date of discharge from treatment, whichever is longer.

_____ *If applicable:* I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize PeoplePsych, LLC to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

_____ I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate the consent any time before the expiration date so long as I submit my revocation in writing this office. Finally, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

_____ I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

_____ I authorize the payment of medical benefits from my insurer to PeoplePsych.

_____ I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

Client's Name: _____

Signature: _____ Date: _____

Responsible Party Name (if other than client): _____

Signature: _____ Date: _____

Notice of Privacy Practices (Brief Version)

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

Our Commitment to Your Privacy

Please note that PeoplePsych is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our patients' personal information. You can be assured that our practice goes beyond what is required by HIPAA.

We are dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. This form is a summary of the full Notice of Privacy Practices (NPP) which is available if you would like more information.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services and for some other business activities which are called, in the law, health care operations. After you have read this NPP and discussed it with your therapist we will ask you to sign a Consent Form to allow us to use and share your information as needed. Please note that PeoplePsych will continue to have you complete releases of information in addition to this document. If you do not consent and sign this form, we cannot treat you.

PeoplePsych utilizes an electronic billing service to process claims via the internet. Our office has taken great care in selecting the billing company with whom we have contracted. Each step in the process is encrypted to ensure the highest standard in privacy regarding sensitive personal information.

If there is a need to disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to` allow this. Of course we will keep your health information private, but there can be rare times when the law requires us to use or share it. Some example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

Questions or Complaints
You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer listed below and with the Secretary of the Department of Health and Human Services by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/, sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, or calling 1-877-696- 6775. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Erin Johnston, LCSW
PeoplePsych, LLC Privacy Officer
312-448-7218 x701

Email and Voicemail Consent (Please circle **YES** or **NO**)

YES **NO** PeoplePsych, LLC may communicate with me about billing and scheduling via email. If "yes", I understand that PeoplePsych cannot guarantee the security of email communication especially related to treatment information. I further understand that my Personal Health Information (PHI) may be at risk if I chose to communicate with my therapist via email about treatment and I assume sole responsibility and liability for this risk.

YES **NO** PeoplePsych, LLC may leave a message on client's/family voicemail confirming your appointment and/or to provide information you requested regarding your treatment.

Signature of Client _____ Date: _____

Parent/Guardian: _____ Date: _____
(Please specify relationship to client)

Responsibility for Fees & Credit Card Authorization Form

I hereby acknowledge that I am personally liable for all fees for services performed on my behalf by PeoplePsych LLC ("PeoplePsych"). These fees includes full session charges for those without insurance; charges passed on to the client from the insurance company including deductible and co-pay charges; and all unreimbursed insurance claims.

While PeoplePsych will submit claims on my behalf to health insurance companies where possible, I am fully liable for such charges that are not paid in a timely manner by the insurance company. I irrevocably agree that any bill that remains unpaid 30 days after submission may, at PeoplePsych's sole option, be charged to my credit card.

I hereby authorize the credit card company listed below to recognize and approve charges against the credit card listed below as submitted by PeoplePsych. I certify that the below listed card is issued to me, and/or that I am an authorized signatory on the account; and that said card is currently valid. I further agree to maintain and keep on file with PeoplePsych a valid credit card at all times.

This credit card authorization form is kept on file for billing purposes and is used only in the event that an outstanding bill is not paid after sufficient notice that it is due. As stated in the client agreement, all fees, deductibles, co-pays and co-insurance are due by check or cash at the time of service.

Client Name _____

Name on Credit Card _____

Type of Card **VISA** **MasterCard** **AMEX** **Discover**

Credit Card No. _____

Expiration Date _____ CVC* No. _____

Billing Address _____

City _____ State _____

Zip _____ Phone _____

I understand that this card will only be used to receive payment for services received from and billed by PeoplePsych, LLC to client named above. I agree to pay the charges for which I am billed if I have chosen not to pay using another form of payment.

Authorization Signature: _____ Date: _____

Print Name: _____

*CVC: A Card Verification Code, or CVC, is a number that provides extra security to credit and debit card holders, in case an unauthorized person gets a hold of your account number. CVCs are one way to make sure someone has the actual card in his or her possession.

The CVC on American Express cards is four digits, and is located on the front of the card, on the right side. Discover, MasterCard, and Visa use three-digit CVCs, which are listed on the back of the card. The CVC is the last three digits of the number that appears on your signature bar.