**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

# Paperwork Check List

☐ **Adult Intake History Form**: Complete applicable areas and **return prior to intake**.

☐ **HIPAA Consent Adult**: Review, sign and **return prior to intake**.

☐ **Release of Information - Physician**: This is an optional physician's release should you wish to allow communication between our office and the primary care physician or other healthcare professional.

☐ **Office Policy ADULT**: Review, sign and **return <u>final page</u> prior to intake**.

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

# Adult Intake History Form

| | | | |
|---|---|---|---|
| **Patient Name:** | | **Date of Birth:** | **Today's Date:** |
| **Marital Status:** [ ] Married [ ] Divorced [ ] Single [ ] Separated [ ] Other: | | | **Gender: [ ]** Male [ ] Female |
| **Address:** | Street: | | |
| | City | State | Zip |
| **Phone Numbers (put only those we may call, and identify them as needed. Example: "mom's cell"):** | | | |
| Home: | | Mobile: | |
| Work: | | Alternate: | |
| **Employment:** [ ] Employed [ ] Unemployed [ ] Full Time Student: Grade: _____ [ ] Part Time Student: Grade: _____ | | | |
| **If in school, what is the school name?** | | | |
| **Email Address (only provide if you are giving permission for us to email you):** | | | |

| | | | | |
|---|---|---|---|---|
| **How would you like to receive appointment reminders?** | [ ] Email | [ ] Call | [ ] Text | [ ] None, thank you. |

| | | |
|---|---|---|
| **Emergency Contact:** | **Phone Number:** | **Relationship:** |
| **Address (if different):** | | |

**Insurance Information:** If you plan to use insurance for payment this information is needed to bill insurance company.

| | | |
|---|---|---|
| **Insurance Company Name:** | **Policyholder's name:** | |
| **Insurance ID #:** | **Group #:** | |
| **Relationship to Patient:** | **Policyholder DOB:** | **Employer:** |

*****If the patient is covered under a secondary insurance policy please discuss this with the office staff.***

## History of Present Problem

Describe your main concerns or problems (symptoms, duration, frequency):

Describe the reason you are seeking treatment at this time:

List any services or interventions you would like to receive and any goals you hope to achieve with treatment:

## Past Psychiatric History

Have you received any of the following mental health or behavioral services before?

| | |
|---|---|
| Inpatient hospitalization | Partial hospitalization |
| Outpatient services | Wraparound services |
| Family-based mental health | Residential treatment facility |
| Drug and alcohol treatment | MH/MR case management |
| Medication prescription/management | AA/NA attendance |

Other (explain):

Have you been given a prior diagnosis? If so, explain:

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

## Trauma History

Have you ever experienced abuse or a trauma? Briefly explain:

## Family Psychiatric History

Please note any family history of learning, developmental, attention, behavior, emotion, mental, or medical problems:

List agencies/caseworkers/clinicians currently working with you/your family on the problems noted above, if any:

## Medical Conditions & History

| How is your overall health? | [ ] Poor | [ ] Fair | [ ] Good | [ ] Excellent |
|---|---|---|---|---|

Please list any current or past health concerns (ex. Asthma, high fever, major surgery, hospitalization):

| Approximate date of last physical examination: _____<br>Where/By Whom? | Have you suffered any head injuries? Yes No<br>If yes, when? |
|---|---|

List any allergies:

## Substance Use

| Do you currently drink alcohol? | [ ] Yes [ ] No | How often? | [ ] Rarely [ ] 1-2 days/wk [ ] 3-6 days/wk [ ] Daily |
|---|---|---|---|
| Do you use any drugs (ex. nicotine, caffeine, cannabis)? | [ ] Yes [ ] No | What, how much, and how often? | |
| Have you used any drugs in the past? | [ ] Yes [ ] No | What, and when? | |

## Family History

Check all that best describe your current living situation:

[ ] Alone [ ] With Spouse/Family [ ] With Parents/Family [ ] With Significant Other
[ ] Apartment [ ] House [ ] Homeless/Shelter [ ] Other:

| Primary language spoken at home: | | |
|---|---|---|
| Is a second language spoken at home? What? | | Fluency: [ ] Fluent [ ] Limited [ ] None |
| Any major stresses in the family that have affected you (ex. death, divorce, etc.)? | | |

List the names and information for all individuals living in the household (include caregivers, children, roommates, etc.):

| Name | Age | Relationship | Comments/Concerns |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Do you have children living outside your home? [ ] Yes [ ] No | If yes, list names, ages, and relationship: |
|---|---|

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

## Social History

| | | |
|---|---|---|
| Did you have problems getting along with other children as a child? | [ ] Yes | [ ] No |
| Do you have difficulty making and keeping friends? | [ ] Yes | [ ] No |
| Do you find being in a social situation difficult? | [ ] Yes | [ ] No |
| Do you have any current social or relationship concerns? | [ ] Yes | [ ] No |

If you checked yes for any of the above questions, explain your response:

## Developmental History

| | |
|---|---|
| Were there any difficulties with your mother's pregnancy? [ ] Yes [ ] No | Explain: |
| Were there any notable developmental delays in your childhood? [ ] Yes [ ] No | Explain: |

## Education and Occupational History

List the **most recent school** the patient has attended:

| School & Location (City, State) | Highest Grade level or Degree completed | Comments/Problems |
|---|---|---|
| | | |

| | |
|---|---|
| Did you *ever* repeat or skip a grade? [ ]Yes [ ] No | Explain: |
| Were you ever evaluated for special education services in school? [ ] Yes [ ] No | Explain: |

Describe your academic and behavioral strengths and weaknesses in school:

Provide information on your job history, beginning with the most recent:

| Employer | Dates of Employment | Job Title | Reason for Leaving |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| Have you ever been fired or let go from an employment position? [ ] Yes [ ] No | Explain: |

## Legal History

| | | |
|---|---|---|
| Were you ever arrested or have you had legal charges filed against you? | [ ] Yes [ ] No | Explain: |
| Are you currently on probation or parole? | [ ] Yes [ ] No | Explain: |

## Strengths/Limitations and Other Information

Strengths/Limitations:

Provide information on your interests/dislikes:

Write any additional comments that may assist in your evaluation and therapy:

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

| Medications | | | |
|---|---|---|---|
| Are you currently taking any medications? [ ] Yes [ ] No [ ] I do not wish to disclose | | | |
| **Medication** (Please include ALL taken including over-the-counter, vitamins, nutritional supplements, etc.) | **Dosage/Frequency** | **Route of Administration** (oral, injection, liquid, etc.) | **Managing Physician** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

## Consent Regarding Notice of Privacy Practices for Protected Health Information

I understand that I have certain rights to privacy regarding my *Protected Health Information (PHI).* These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. I consent to the use or disclosure of my/my child's PHI by *Cognitive Health Solutions, LLC* (CHS), for the purposes of (1) diagnosing and/or providing treatment to me/my minor child; (2) obtaining payment for my/my minor child's health care bills; and/or (3) to conduct routine health care at their office.

If, based on professional judgment, it is suspected that a child has been abused we are required to report suspicions to the authority or government agency vested to conduct child-abuse investigations. We are required to make such a report even if we do not see the child in a professional capacity. We are mandated to report suspected child abuse if anyone aged 14 or older tells us that they committed child abuse, even if the victim is no longer in danger. We are also mandated to report suspected abuse if anyone discloses that he or she knows of any child currently being abused.

I understand that I have a right to review the *Notice of Privacy Practices (NPP)* which contains a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I acknowledge that CHS reserves the right to change the privacy practices described in the *NPP,* and I may obtain a revised *NPP* by calling the office and requesting that a revised copy be sent in the mail and/or asking for a copy at the time of my or my child's next appointment. I understand that after signing this consent form I may revoke it in writing at any time, but any previously shared information cannot be retrieved.

**********

***Please read this before you sign this Consent form. If you do not sign this consent form agreeing to our NPP, we cannot complete an evaluation or provide any psychological services to you or your child.***

***A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR COGNITIVE HEALTH SOLUTIONS, LLC IS AVAILABLE IN THE WAITING ROOM AREA.***

| **Patient Name (print)** | **Patient Signature (if 18+)** | **Date** |
|---|---|---|

***If joint legal custody exists, both parents/guardians must sign**

| **Mother/Legal Guardian Name (print)** | **Mother/Legal Guardian Signature** | **Date** |
|---|---|---|

| **Father/Legal Guardian Name (print)** | **Father/Legal Guardian Signature** | **Date** |
|---|---|---|

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

# Authorization to Release Information to Physician/Psychiatrist

Patient Name: Date of Birth:

I hereby authorize Cognitive Health Solutions, LLC to: ☐ Release to ☐ Obtain from

Person or Facility:

Person or Facility Phone #: Person or Facility Fax #:

Person or Facility Address:

☐ I **DECLINE** CHS to obtain/ release information with my PCP for the continuity of my care.

☐ I **ALLOW** CHS to obtain/release information with my PCP for continuity of my care (specifications below)

| | | | |
|---|---|---|---|
| ☐ | **All available information and records (all of the information listed below, including, but not limited to, mental health and substance abuse information) may be release to and received from the practice listed above** | | |
| ☐ | Psychological/Psychiatric evaluation, diagnosis, treatment, and recommendation information | ☐ | Contact, scheduling, & demographic information |
| ☐ | Laboratory tests with imaging results (ex. X-Ray, MRI) | ☐ | Professional observation, opinion, and impression |
| ☐ | Intake, family/social history, and treatment history | ☐ | Medication history, prescriptions, medical diagnosis, medical treatment |
| ☐ | Substance abuse assessment and treatment information | ☐ | Achievement/Educational Records |
| ☐ | Legal history/involvement with the court system | | |
| ☐ | Other (specify): | | |

For the purpose of: ☐ Continuity of Care ☐ Treatment Planning ☐ Discharge Planning ☐ Other:

You have the right to revoke this authorization, in writing, at any time by sending a written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer have a legal right to contest a claim.

I understand that the information in my health care record may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

I understand that services are not conditioned upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule. This consent will expire: One Year .

Signature of Patient (if 18+ years old) Date

Signature of Mother/Legal Guardian #1 (if patient is under 14 years old) Date
***If joint legal custody exists, both parents/guardians must sign**

Signature of Father/Legal Guardian #2 (if patient is under 14 years old) Date

Signature of Witness (if 18+ years old)

**To Recipient:** This information has been disclosed to you for your records alone. Confidentiality is protected by Federal Law. Federal Regulation 42FR, part 2, prohibits you from making any further disclosure of this information, in writing or otherwise, without the specific written consent of the person whom it pertains or as provided by such regulations.

**Main Office (Hanover):**
100 West Eisenhower Drive
Hanover, PA 17331
Phone: (717) 632-8400
Fax: (717) 632-9300

**York Office:**
1030 Plymouth Road
York, PA 17402
Phone: (717) 747-3659
Fax: (717) 885-5550

# Office Policies Agreement and Consent for Behavioral Health Services

## ADULT FORM
## Office Policies

**Appointments**

*Cognitive Health Solutions, LLC* (CHS) provides all professional services by appointment, except in cases of unusual urgency. Initial appointments are used to obtain background and clinical information, and they are scheduled for 60-90 minutes. Routine scheduled outpatient therapy appointments are generally 45 minutes in duration. Psychological evaluation services require several hours, and they are scheduled differently. Following the initial appointment, the length and frequency of evaluation appointments will be discussed with you. It is important for you to be on time for your appointments, as this allows our office to remain on schedule. We ask that you arrive 10 minutes prior to your first appointment to ensure all paperwork is in order. If you are more than 15 minutes late for an appointment, the appointment will need to be rescheduled and you will be responsible for a $40.00 missed appointment fee in accordance with our *Missed Appointment Policy* below.

**Crisis/Emergency Appointments.** If you need to schedule a crisis or emergency appointment, you should contact our office. Please follow the guidelines listed under *Contacting the CHS Office/Providers* below. There may be an additional cost for crisis/emergency appointments scheduled outside of the typical hours. This will be billed to your insurance if CHS is part of your network. If not, you may be responsible for this fee.

**Missed Appointment Policy**

When given an appointment, that time is reserved for you alone. We typically have a list of people waiting for initial appointments and lists for people waiting for cancelled appointments (particularly for 3:30PM and later). Please be courteous, and when at all possible, provide as much notice as you can if you must cancel or reschedule an appointment. We ask that you provide notice of at least 24 hours. Should you have a late cancellation, no show, or late arrival for your appointment, this will be considered a missed appointment. We define a missed appointment as follows:

> ***Late Cancellation*:** Notice of less than 24 hours of your inability to attend a scheduled session.
>
> ***No Show*:** Failure to provide any notice of your inability to attend the session prior to the appointment time.
>
> ***Late Arrival*:** Arrival of more than 15 minutes late for your appointment without notice and your appointment needing to be rescheduled.

Missed appointments exclude serious emergencies or sudden illness. The death of a family member, natural disaster, accident, weather conditions, or severe illness of a family member living at home, all qualify as emergencies. A business meeting, final exam, another doctor's appointment, minor illness (e.g., cold), or sleeping in, would not qualify as an excused session.

We use the following policy guideline in cases of missed appointments.

> **New Patient.** If you do not show up for your first scheduled appointment with no notification prior to the beginning of the appointment, you will be placed at the end of the current waitlist. We will not reschedule anyone missing more than one initial appointment.
>
> **First Missed Appointment.** Upon your first missed appointment, you will receive notification in the form of a letter indicating that you missed your appointment and reminding you of the *Missed Appointment Policy*. There will be no missed appointment charge assessed for the first incident.

**Second and Third Missed Appointments.** You will receive notification in the form of a letter indicating that you missed your appointment and reminding you of the *Missed Appointment Policy*. A $40.00 missed appointment fee will be charged to your account and will need to be paid prior to your next visit.

**If two consecutive appointments are classified as Missed Appointments as defined above a verbal confirmation of the next scheduled appointment must be received more than 24-hours before the next scheduled appointment or all appointments will be cancelled to avoid accruing multiple appointment fees.*

**After Three Missed Appointments.** After having three missed appointments in a 12 month period, any additional missed appointments will result in either a discharge from services at our office or the option to pay our full out-of-pocket fee for the scheduled service for each subsequent missed appointment. *Due to the high demand for evening and weekend time slots (appointments beginning at 3:30 PM or later, or Saturday appointments), patients having three or more missed appointments will only be able to schedule daytime appointments (between 8 AM to 3:30 PM on Monday through Friday).*

***NOTE:*** *This is a reminder that insurance companies **will not** pay for missed appointment fees, and you acknowledge that any fee incurred due to a missed appointment will be your responsibility.*

**Contacting the CHS Office/Providers**

Although your provider will typically be available during regular business hours, he or she is often not immediately available by telephone and does not accept calls while in session. You may leave a message with the front office staff or leave a message on the provider's voice mail. Voice mails are confidential and your message can only be accessed by professional providers or administrative staff. Providers make all attempts to return messages by the end of the work day. However, there are times when it may take longer for a return call. Please do not leave any urgent information on voicemail, and instead, leave a message with our front office staff. **In life-threatening situations, immediately call 911 and/or go to the local hospital emergency room.** If a nonlife-threatening crisis occurs during nonbusiness hours, call the office phone line (717-632-8400) and follow the prompts to leave a message for the on-call provider. By leaving a message on the emergency message system, the on-call provider will be paged. Your call should be returned within 15 minutes. If it is not, we encourage you to call the office and follow the prompts again. If for some reason you still do not receive a return call, go to the local emergency room. The on-call provider is not always the provider you see on a regular basis, though he or she will be able to help.

We understand that email is a frequently used form of communication, and this is an option for contacting the CHS office and our providers. However, we must make you aware that while we take precautions to keep email secure; there is no way we can fully ensure its security. Thus, if you choose to use email as a form of communication, please do not include sensitive information. In addition, **email is not to be used in the case of emergency**, and instead, you should call our office at (717) 632-8400 for all urgent situations.

**CHS Office Facilities**

**General Office Conditions.** We deem our office premises to be reasonably safe; however, you should present for your appointments at your sole discretion, with awareness and responsibility for any natural risks (e.g., stairs, windows, potholes in pavement). You may cancel an appointment without penalty or fees in any situation in which you deem the office premises unsafe (e.g., icy conditions in the parking lot). Although every attempt is made to maintain safe premises, your signature on this agreement indicates that you are accepting sole responsibility for your safety while in, on, or around our office premises. You understand and agree that CHS is not responsible and cannot be held liable for any negative consequences of damages related to the premises, inside or outside of the building.

**Winter Precautions.** Please be very cautious when walking in the parking lot during the winter to avoid slipping on ice or snow. If the weather prevents you from making your appointment, please **call to cancel** so we know that you are not coming. This is greatly appreciated. In the event that our office needs to close during regular business hours, we will make all attempts to reach you prior to your appointment using the phone numbers provided. In addition, **our practice posts any weather closings on WGAL.com/weather under Adams County** for all practice locations. If you are concerned about travel conditions, please call our office prior to leaving. You may cancel your appointment without penalty should weather conditions affect your attendance.

**Children and Minors.** Children on our premises must have adult supervision at all times. Any toys available in the waiting area are intended for use according to the discretion and supervision of the parent/caregiver. Parents/caregivers are responsible for being aware of and ensuring safety around natural physical dangers, such as windows and stairs. Please be notified that children and minors are not allowed to remain in the waiting room unsupervised and an adult must accompany them to the restroom. There will be no one available to supervise children who are not involved in the session, and every effort should be made to bring only the individuals involved in the session or services (or bring an adult to supervise children in the waiting area).

**Psychological and Behavioral Health Services**

Participation in psychological or behavioral health services can have both risks and benefits. Evaluation and therapeutic services often involve discussing unpleasant aspects of life or stressful situations. Individuals in therapy may experience uncomfortable feelings (e.g., anger, sadness, and guilt), emotional distress, and/or increased behavioral problems. However, participating in these services can also yield many benefits, including improved emotional functioning, social relationships, and alleviation of emotional and psychiatric disorders. However, there are no guarantees with regard to the effectiveness of psychological and behavioral health services or for the patient's (and participating family members') experience of risks and benefits.

CHS provides all psychological and behavioral health services within the guidelines of the professional, ethical, and legal standards established for the provision of these services. If you have any concerns regarding any aspect of the evaluation or treatment services, the provider working with you is available to respond to your concerns or questions. You have a choice in providers and are under no obligation to receive services from CHS. Your signature on this Agreement provides your consent for yourself, and any participating family members, to receive all of the assessment and treatment procedures deemed necessary and appropriate by the treating provider. Your signature on this Agreement also indicates that you understand there is the possibility, as with all types of treatment services, that your (or participating family members) participation in psychological and/or behavioral health services could possibly have unfavorable effects on your personal, family, legal, or financial situation.

**Professional Record Keeping**

The laws and standards require that the psychological and behavioral healthcare providers maintain clinical records of all services provided. The following information may be included in your clinical record: reasons for seeking services; symptoms; diagnosis; treatment plan; session information and progress; medical, social, and family history; records from other providers; billing information; phone calls and other communications; information provided by other individuals; and other information related to the clinical services. Any paper medical records are maintained in a locked location and kept onsite. When possible, paper records will be scanned into a digital format and saved within our electronic medical records system. All electronic medical records (EMR) are maintained as part of our EMR and practice management (PM) software. This information is maintained as part of a HIPAA complaint on-line program.

**Limits on Confidentiality**

Detailed information about the CHS policies on protected health information (PHI) can be found in the office's *Notice of Privacy Practices for Protected Health Information*, which is available in the office waiting area or by request. You will be asked to sign a *Consent Regarding Notice of Privacy Practices for Protected Health Information,* which acknowledges your receipt and understanding of our policies. The Notice provides details regarding limits on confidentiality and requirements for the disclosure of your PHI, which we summarize here. Neither your consent nor authorizations are required for the release of your PHI if: (1) there is a suspicion of abuse or neglect of a child even if we do not see the child in a professional capacity. We are required to report suspected abuse if anyone aged 14 or older tells us they committed child abuse, even if the victim is no longer in danger, or if anyone discloses that he or she knows of any child currently being abused; (2) there is suspicion of abuse or neglect of an elderly person, or disabled person; (3) there is a belief that you are in danger of harming yourself or another person or you are unable to care for yourself; (4) there is suspicion that you intend to physically injure someone; (5) there is a court order that exists to release information; (6) there is a request from a government agency to review information for health oversight activities; (7) you file a complaint or lawsuit against CHS or any CHS employee (your entire treatment file can be used within the legal defense); (8) there is a natural disaster whereby records may become exposed; or (9) when otherwise required by law. These situations are very unusual and the laws regarding confidentiality are complex. You should speak with your treating provider regarding any questions regarding this information.

In most situations, CHS and our providers can only release information regarding your psychological and behavioral health services if you sign an authorization form that meets the legal requirements imposed by HIPAA. Your signature on this Agreement offers consent for the following:

- Occasionally the treating provider may need to consult with other professionals regarding treatment. Every effort is made to avoid revealing your identity. In these cases, other professionals are also legally bound to keep the information confidential. Typically, these consultations are not discussed directly with you, as they function to provide you with the highest quality of care.
- CHS employs behavioral health providers and administrative staff. Your PHI may be shared with other CHS staff for clinical and administrative purposes. All CHS staff members are required to protect patient privacy and we will not release any information outside of CHS without your consent.
- If the treating provider deems your emotional or behavioral functioning to be a crisis or concern (at the sole discretion of the treating provider), he or she is authorized to contact any individuals necessary to assist with stabilizing your functioning to safe levels and to attempt to insure safety.

**Legal Matters**

The clinical services provided by CHS and our staff are **not** forensic in nature, and you understand that the services under this agreement are not for custody purposes, disputes, or legal matters. CHS providers do not engage in forensic services with individuals they see for clinical treatment or services. Therefore, you knowingly and freely waive your right to request the release of information to your attorney or any other Officer of the Court for custody or legal purposes. The release of clinically significant information to any Officer of the Court shall be by Court Order only, signed by a duly appointed judge. If a Court Order is issued, you understand that we do not need your authorization to release this information. Those individuals interested in forensic services will need to obtain a separate agreement and contract, which stipulates the nature and costs associated with those services.

**Financial Policy**

CHS is committed to providing the best possible care, and your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities. Most of our fees are established as an hourly or per session rate and are billed accordingly. However, some of our services are billed as a flat rate. Our current *Fee Schedule* is posted in the CHS waiting area or is available upon request. Please note those fees are subject to change without prior notification.

Health insurance is one means of payment, though your health insurance coverage can only be billed for services that are deemed **"medically necessary."** Some services provided at our office are not covered by your health insurance, such as psychoeducational evaluations, educational consultation, educational remediation services, psychoeducational skills groups, cognitive training programs, etc. Fees for these services will be billed directly to you, unless otherwise determined. Your signature below acknowledges your understanding that you are responsible for payment for agreed upon services provided, which are not medically necessary services.

Please remember that insurance and behavioral health plans are methods of reimbursement for medically necessary services, though they are not a substitute for payment. In some cases, insurance providers will reimburse a percentage of the professional fee. Different insurance companies pay different percentages. Your signature below indicates your understanding that you are financially responsible for all copays, coinsurance, payment applied to your deductible, and fees not covered, as allowed by our contracts with your insurance carrier for medically necessary services.

**For Health Insurance and Contractual Payers (e.g., OVR, EAP).** CHS will bill your healthcare insurance plan and follow the contractual obligations that exist between your plan and CHS. As a general policy, our office will **only** file insurance if our office and/or providers participate in a specific plan. If not, it is your responsibility to seek reimbursement. You have the obligation to be aware of the provisions of your health insurance and your requirements to obtain benefits. Please notify us of any **healthcare insurance changes** before services are provided under the new coverage. Many health insurances require a preauthorization, and if we are not notified of changes prior to service delivery, your health insurance will deny payment for those services and you will be responsible for the full fee. If you are expecting your insurance to pay the fees, it is extremely important that you notify us of any insurance policy changes. For patients being seen for services through OVR, EAP, or BDD, there is no payment required from you directly, as these services are preapproved.

If your insurance requires a preauthorization, please bring the authorization number you are given to your appointment. ***We suggest that you contact your insurance company with questions prior to the appointment.*** Please ask your insurance company the following questions. Bring this information to your appointment.

1. Is Cognitive Health Solutions, LLC or [the name of the provider] a participating provider?
2. Does my insurance cover the services I am seeking?

3. Do I have a deductible?
4. Do I have a maximum number of sessions?
5. Do I have a copay or coinsurance?
6. Do I need precertification or preauthorization?

CHS uses an electronic scheduling and billing system. Information needed for scheduling and billing is maintained and transmitted through secured servers using encryption and other security measures. The information does not include your social security number (or the insurance subscriber's social security number) or confidential clinical records (e.g., content of sessions, treatment notes, etc.) and this information is **NOT** transmitted through our internet-based billing program. CHS makes every effort to release only the minimum information necessary for insurance companies. Although all insurance companies are required by law to keep such information confidential, CHS has no control over what they do with it once it has been provided to them. You should call your insurance company if you have any questions about how they use and secure your information.

Your signature on this Agreement provides your permission for CHS to maintain and transmit your scheduling and claims/billing information through our encrypted, secured internet service, claims processing center, and your health insurance's electronic claims processing department, as well as traditional mail, when needed. Your signature below authorizes (1) the use of PHI for treatment, payment, and health care operations; (2) the disclosure of all information necessary, including mental health and substance abuse information, to obtain preauthorization, certification, or approval from your insurance company, to submit and process claims for payment, and to provide quality assurance and utilization of information to your insurance company; and (3) the payment of insurance benefits for services rendered to CHS.

**For Out-of-Network Insurance.** If CHS does not participate with your health insurance plan, you must pay for the appointment at the time of service at the fee rates according to our fee schedule (see *Fee Schedule* posted in waiting area or available on request). Should you choose to obtain out-of-network reimbursement from the insurance company, it is your responsibility. Our office does not accept fees from insurance companies we do not have contract with, and our office will not complete their paperwork requirements or bill these insurance companies directly. If you have any questions on how to file a claim or interpret your Explanation of Insurance Benefits (EOB), please contact your insurance company or the human resources department at your place of work.

**Payment.** ***Please note that all self-payments, copays, coinsurance, and deductibles are due at the time of service and will be collected before your session.*** For your convenience, our office accepts cash, personal checks, MasterCard, Visa, and Discover. Please note that all checks are deposited same-day. **Returned checks will result in an additional $35.00 fee** to cover bank charges and processing costs. A missed appointment (as defined above) will result in a $40.00 fee charged.

CHS policy requires that **ONE** individual accept financial responsibility for services rendered to the patient. In a shared custody of a minor child situation, CHS will not accept responsibility for determining who is responsible for which percentage of fees or collecting/invoicing percentages to multiple individuals. Prior to the first appointment, it must be established who will be responsible to receive all invoices for services rendered. This information will be provided on the *Financial Responsibility Form*.

**Overdue Accounts.** There is a 2% late fee charge per month based on the balance owed for all outstanding accounts. Outstanding accounts are defined as any account in which we have not received payment for 30 days or more, unless we are waiting for insurance reimbursement. If an account is past due for more than 90 days, a collection agency may be used to obtain payment. Your signature below acknowledges that contact and billing information will need to be released in these case, and you understand and agree for information to be released to a collection agency if your account is more than 90 days past due, unless other arrangements have been made. When accounts are placed with an outside collection agency a **collection fee** of 5% of the balance owed will be added to your outstanding balance. If you have an outstanding balance, we will not schedule new appointments, unless consistent payment arrangements have been made and followed.

**Concerns and Changes**

Although these policies provide general information regarding CHS, we recognize that you may have additional questions or concerns. Please feel free to bring these to our attention. We want to provide a service that will be successful and beneficial. Any concerns should be discussed with treating providers or front office staff. Any concerns that cannot be resolved by those means should be discussed with Dr. Ray W. Christner, CEO.

Changes may be made to CHS policies without advanced notice to patients, when needed. We will post all changes in the waiting area or make them available at your next appointment.

This page is intentionally left blank; the office will remove and keep page 7: Consent of Agreement.

**Consent of Agreement**

CHS will retain a copy of this signed page as part of your medical record. The remainder of this document is for your records and reference. Your signature indicates that as of the revision date shown on each page of this document you are in agreement with our updated policies. CHS will post any changes to this document in the reception/waiting area of our office, and those changes will take effect on the day they are posted. In the case of significant changes, you will receive a copy of the new policy agreement and be asked to resign this form.

Your signature below indicates that you are providing your informed consent to participate in psychological or behavioral health services provided by CHS. You agree to hold harmless and release from all liability the CHS providers and staff for any negative effects or damages that may result from your participation in said services, release of information, and/or the fee collection process.

You are agreeing that if you, or anyone on your behalf, file a lawsuit, licensure, or ethics complaint, or take any other legal action against CHS and/or any employee(s) of CHS concerning any aspect of your participation in services, and there is a favorable ruling for CHS and/or any CHS employee(s), you will be responsible for all legal, professional, office, and court costs for the complaint or suit filed by you or anyone on your behalf. These costs will be due 30 days from the determination in favor of CHS and/or CHS employee(s).

When you sign this Agreement, any previously signed Agreements are void and are no longer in effect. You may discuss any concerns with the treating provider or office staff before signing.

Your signature indicates that you have read, understand, and agree to the terms of this Agreement, as well as the policies of CHS outlined above.

| **Printed Name** | **Signature** | **Date** |
|---|---|---|