Welcome to Healing House Counseling,

We are pleased you chose us for your counseling needs, and we look forward to working with you. We offer a safe space for you to work on your goals. We believe healing is possible, and we are dedicated to providing the best counseling services. Here at Healing House Counseling we believe if you take an active role in your counseling experience you will have the best possible outcome. We are here for you and available to discuss any questions you may have.

Prior to your first appointment, it is important that you contact your insurance provider and discuss our fees and inquire as to whether they accept your counselor’s credentials. Ultimately, you are responsible for the fees for services rendered. Our office is open Monday through Friday. There is no childcare available. In the case of an after-hours emergency, please call 911.

Healing House Counseling will assist you in addressing and resolving your concerns. We believe as you and your counselor work together to address your concerns, you will develop a sense of self-awareness that will influence your behavior and feelings. As a client, you are in complete control and may end our professional relationship at any point. We will be supportive of that decision. We also have the option of ending our counseling association if we determine it is in the best interest of both parties. If counseling is successful, you will feel better able to face life’s challenges in the future without our support or with limited intervention.

We will keep confidential anything you say to us, with the following exceptions: (1) you direct us to tell someone else; (2) we determine you are a danger to yourself or others; (3) there is suspicion of child abuse or abuse of a vulnerable person; and/or (4) we are ordered by a court to disclose information. ​**(initial**

**\_\_\_\_\_\_)**

Complete information about Healing House Counseling is included in the Professional Disclosure Statement you received. ​**(initial \_\_\_\_\_\_)** . Healing House Counseling assures you that our services will be rendered in a professional manner consistent with accepted ethical standards. Please note it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

If you have any questions, feel free to ask. Please initial, sign, and date this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor/Facilitator Signature Date

# Professional Disclosure Statement

Healing House Counseling

101 B Weed St.

St. Marys Georgia 31558

(907) 385-2165

**Providers:**

Cassey St. Rose, LPC

**Fee Schedule**

|  |  |
| --- | --- |
|  |  |
| Individual and marriage sessions (30-50 minutes) | $125.00\* |
| Individual and marriage sessions (50-90 minutes)  Group counseling sessions 1 hour 30 minutes: $100.00\* per session  Online counseling sessions (30-60 minutes) ($30- $60)\* | $175.00\* |
| No-shows and late cancellations  *\*Subject to change without notice*    **Payment** | $75.00\* |

*Deductible and Co-pay payments are required at each visit*. Cash, check, debit, or credit card are accepted for payment.

**Cancellation Policy**

If you miss your scheduled appointment, and you have not notified us at least 24 hours in advance, you will be required to pay a cancellation fee.

This information is required by the Board of Professional Counselors which regulates all licensed professional counselors.

Board of Professional Counselors

237 Coliseum Drive, Macon, Georgia 31217-3858

Board of Professional Counselors

Division of Occupational Licensing PO Box 110806

Juneau, AK 99811-0806

# Client Information

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If Minor) Last First MI

Mailing

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_Zip\_\_\_\_\_\_\_

Private

e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healing House Counseling can leave a message at : □ Home □ Work □ Cell Phone □ Other \_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_

Marital Status: Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Insurance Information

Primary Insurance​: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_Relation to Client: \_\_\_\_\_\_\_

Secondary Insurance​: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_Relation to Client: \_\_\_\_\_\_\_

*I understand all payments for treatment received are my responsibility. I authorize the release of any information to my insurance company that is required to process a claim on my behalf. I authorize my insurance company to remit payment for any medical benefits due, directly to Healing House Counseling.*

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_

# 

# Counseling/Medical History

Have you previously sought counseling? Yes\_\_\_ No\_\_

If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Health Status Excellent Good Fair Poor

How long has it been since your last physical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Chemical Use

History: Yes No Current: Yes\_\_ No\_\_

Substances

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Longest period of sobriety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Treatment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a religious, faith, or spiritual belief system? Yes\_\_\_ No\_\_

If yes, what is your belief system? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counseling/Medical History Continued**

Rate the items with which you are currently having problems. Circle the number that best indicates the existence or severity of the problem.

0=None 1=Minor 2=Moderate 3=Significant 4=Serious

**Circle the word(s) in brackets that best define(s) each statement**

Anxiety [Worry] [Fear] [Panic] [Phobia] 0 1 2 3 4

Feelings of [Depression] [Sadness] 0 1 2 3 4

Thoughts of [Death] [Suicide] 0 1 2 3 4

Sleep Disturbance 0 1 2 3 4

Mood Swings 0 1 2 3 4

Grief over [Death of Loved One] [Major Loss] 0 1 2 3 4

Issues Related to[Pregnancy] [Abortion] 0 1 2 3 4

Abuse [Physical] [Domestic] [Emotional] [Ritual] 0 1 2 3 4

Sexual Abuse [Incest] [Rape] 0 1 2 3 4

Parent(s) had [Alcohol] [Drug] Problem(s) 0 1 2 3 4

Marriage Problems 0 1 2 3 4

Relationship Problems with Children 0 1 2 3 4

Problems with [Parents] [Family] 0 1 2 3 4

Sexual [Concerns] [Problems] 0 1 2 3 4

Problem [Alcohol] [Drugs] [Smoking] [Other] 0 1 2 3 4

Feelings of [Hopelessness] [Helplessness] [Despair] 0 1 2 3 4

Memory [Forgetfulness] [Changes] 0 1 2 3 4

Have you ever felt people were watching you? Yes No

Do you hear voices? Yes No

Do faces ever seem distorted? Yes No

Do colors ever seem too bright or dull? Yes No

Have you attempted suicide? Yes No

**Counseling/Medical History Continued**

In your own words, state the concerns that bring you to counseling:

**Billing Information**

Healing House Counseling billing rates can be viewed on the Professional Disclosure Statement. ​​Our billing rate is based on the reasonable and customary charges billed by other counseling services in the St. Marys area. Our goal is to assure quality of service and that whoever needs our counseling services is not denied due to economic need.

Healing House Counseling offers a number of options regarding the payment of your bill. **Please**​ **indicate below** ​***your commitment of payment for services rendered.*** ​​If you are in need of special assistance regarding payment of services, please check the appropriate box of listed billing options below.

|  |  |
| --- | --- |
|  |  |
| \_\_\_ | Self Pay: I will pay in full at time of service. |
| \_\_\_ | Insurance: Please provide me with a Superbill that I will submit to my insurance company(s) for reimbursement. (If my insurance company does not pay for the entire amount of the cost of services, I understand I am responsible for the remainder of the charge.) |
| \_\_\_ | I will pay $\_\_\_\_\_\_\_\_ the day of my appointment. (Payment must be made in full for the first visit and all following visits until your insurance company begins to pay for services.) |
| \_\_\_ | Church Voucher: I am coming with permission from my church to receive counseling on a church voucher plan. Please bill the church. Church Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(You must identify the church and have written authorization at the time of your first counseling appointment.)* |
|  |  |
|  |  |
| \_\_\_ | Credit Card Payment: Please bill my credit card for the cost of services.  \_\_\_Visa \_\_\_ Master Card |

Acct.#: ​**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**​Exp. Date: \_\_\_\_\_ ​ ​3 Digit Code: \_\_\_\_\_

*I authorize the release of relevant information to my insurance carrier or other provider as required to establish benefits, and I agree to assign those benefits to Healing House Counseling. This authorization is valid unless I revoke it in writing. It may be revoked or renewed as desired by both parties.*

**Signature Date**

# Financial Policy

A clear understanding of the financial responsibility for your care is fundamental to assuring a healthy and professional relationship with our staff. Please read this form carefully and have your questions answered before signing.

**Our Fees:**

Our fees are derived by using a system called the Regional Based Relative Value System. This is a commonly accepted standard method of setting fees – it uses information based on federal insurance programs and a conversion factor. ​**(initial\_\_\_\_\_\_)**

**Payment:**

We accept cash, check, or credit card.

**Insurance -** ​***Remember that you are ultimately responsible for your bill.***

■ If you have ​**private insurance**​, as a courtesy, we will bill your carrier for our services once per visit. All ​**new patients**​ are asked to pay the full amount of your first visit at the time of the visit. We are happy to bill your insurance and refund you any overpayment. ​**All patients** are asked to pay the full amount of the visit at the time of the visit at **the beginning of the**​ **year**​ until your deductible is met. You will then be asked to continue to pay “your percentage” at the time of subsequent visits. **Any overpayment will be refunded to**​ **you**​**.** ​If your insurance pays and there is still an outstanding balance, you will be billed and the amount owing will be due upon receipt of your first statement from our office. If your insurer has not paid for any reason, you will be billed and are responsible for the balance upon receipt of your first statement from our office. When we receive payment from your primary insurance company, we will bill your secondary insurance ***once***​ ​. ​*Remember that Insurance is a contract between you and your Insurer.* ​ We will be happy to help as we can, and send records, but will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or so-called “usual and customary” reductions.

■ **Tricare, Champus, or ChampVA** clients need to check with your carrier to make sure​ your therapist is covered under your plan. You must secure an authorization code before your first visit.

■ **Church Vouchers**​ are accepted. Check with your church to see if there is a voucher system in place. Your voucher must be authorized and turned in to your counselor before your first visit. If there is no voucher system in place have your church leadership contact Healing House to establish a voucher system.

■ **Medicare**​ and ​**Medicaid** ​are not accepted at this time.

**No-Shows and Late Cancellations**

Healing House Counseling understands that life happens and there are times when you may have to cancel an appointment; therefore, ​**In the event that you are unable to keep an appointment, please notify the counseling office at least 24 hours in advance.** ​If you do not call to cancel or reschedule your appointment, you will be charged for the missed session. **(initial\_\_\_\_)** ​Insurance and/or other third party coverage ​**cannot**​ be billed for no-shows or late cancellations. **(**​**initial\_\_\_\_\_\_)** Missed appointment fees are due and payable before the​ next session. ​**(initial\_\_\_\_\_\_)** There will be a charge​ ​ ​for ​**ALL**​ NSF checks. You may call 907- 385-2165 to make or change an appointment. This authorization shall expire upon written notice.

I have read the above, and preceding pages, and have had my questions answered.

# Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Healing House Counseling Client Notice of Privacy Practices

**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.**

# Our Pledge Regarding Mental Health Information

The privacy of your mental health information is critically important to us. We understand that your mental health information is personal and we are committed to protecting it. We create a record of care and the treatment you receive at our practice. We maintain this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share mental health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of protected mental health information.

# Use and Disclosure of Your Protected Mental Health Information

The following section describes different ways that we use and disclose protected mental health information. Not every use and disclosure will be listed. However, we have listed all the different ways ​***we are***​ permitted to use and disclose mental health information. We will not use or disclose your mental health information for any purpose not listed below without your written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**Examples:**

|  |  |
| --- | --- |
| Treatment Purposes: We obtain treatment information about you and record it in a counselor’s | |
|  | chart. |
| Payment Purposes: | We submit requests for payment to your insurance company. The insurance company requests certain information from us regarding care given. We will provide the required information to them about you and the care given so that you may access your insurance benefits. |
| Operation Purposes: | We obtain services from our insurers or other business associates such as billing, accounting, and legal services. We will share certain information about you with such insurers or other business associates as necessary to obtain these services we require in order to better serve you. |

**Other Disclosures & Uses Required/Permitted by Law Include:**

Abuse & Neglect: All practitioners of Healing House Counseling are ​**mandated**​ by Alaska and Georgia State Law to report suspected abuse and neglect of children, the elderly, and persons with disabilities.

Court Proceedings: We may disclose your protected information in the course of any judicial or administrative proceeding as allowed or required by law, with your specific written consent, or as directed by a judge’s court order. To avert a life-threatening situation, we may disclose your protected information consistent with applicable law to prevent an imminent threat to the health or safety of a person or the public.

|  |  |
| --- | --- |
|  |  |
| Law Enforcement: | We may disclose your protected information for law enforcement purposes as required by law, such as when required by a judge’s court order. We do not routinely release protected information in response to an attorney’s subpoena. |
| Notification: | In the event of an emergency, hospitalization, and with your permission, we may use or disclose your protected information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition. |
| Workers Comp: | If you are seeking compensation through Workers Compensation, we may disclose your protected information to the extent necessary to comply with laws relating to Workers Compensation. |
| Other Uses: | Other uses and disclosures besides those identified in this notice will be made only as authorized by law or with your specific written consent, which you may revoke in writing at any time. |

# Your Information Rights

The health and billing records we maintain are they physical property of Healing House Counseling. The information in it, however, belongs to you.

**You have a right to**​:

* Request a restriction on certain uses and disclosures of your file by delivering the request in writing to our office. We are not required to grant the request, but we will carefully review any request received.
* Obtain a paper copy of this notice by making a request at our office.
* Request that you be allowed to inspect and/or receive a copy of your file and/or billing record. You may exercise this right by delivering your request in writing to our office. Payment of one dollar per page is due when file copies are picked up.
* Request that your file be amended to correct incomplete or incorrect information by delivering a written request to our office. We are not required by law to make such amendments.
* File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your file.
* Obtain an accounting of disclosures of your information as required by law by delivering a written notice to our office. An accounting will not include internal uses for treatment, payment, or disclosures made to you at your request.
* Revoke authorizations that you made previously except to the extent information or action has already been taken, by delivering a written revocation to our office.
* Review this notice before signing any consent authorizing use and disclosure of your protected information for treatment, payment, and operation purposes.

# Our Responsibility

Healing House Counseling​​is required to: Maintain the privacy of your information as required by law; Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; Abide by the terms of this notice; Notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate information about you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of this notice by calling and requesting a copy, or by picking one up at our office.

# To Request Information or File a Complaint

If you have questions, would like additional information, or want to file a complaint regarding the handling of your information, you may file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. Healing House Counseling will not retaliate against you if you file a complaint. We cannot, and will not require you to waive the right to file a complaint with the Department of Health and Human Services as a condition of receiving treatment from our office.

**I have read and understand Healing House Counseling’s Client Notice of Privacy Practices.**

# Signature Date

HIPAA: Client Notice of Privacy Practices 3/22/04