Comprehensive Counseling Connections, PLLC

PATIENT INFORMATION

Patient Name: DOB:

Address:

Home Phone: Consent to leave voice messages? ☐ Yes ☐ No

Work Phone: Consent to leave voice messages? ☐ Yes ☐ No

Cell Phone: Consent to leave voice messages? ☐ Yes ☐ No
Consent to text appointment reminders ☐ Yes ☐ No

Email:

How did you hear about us, or by whom were you referred?

Emergency Contact: Phone Number:

INSURANCE INFORMATION

*Name of Primary Care Physician: Phone:

*Insurance Company: * ID #:

***Do you have a deductible?** ☐ Yes ☐ No ***If Yes, has your deductible been met?** ☐ Yes ☐ No

*Subscriber's Name: *DOB:

*Relation to Subscriber:

*Please indicate if you have obtained mental health services outside of Comprehensive Counseling Connections under the health insurance plan you will be using today. ☐ Yes ☐ No If yes, please indicate the number of visits since January 1st of this year.

*Do you have a secondary insurance? ☐ Yes ☐ No * If Yes, please fill out section below

*Insurance Company: * ID #:

*Subscriber's Name: *DOB:

A. *I give my consent for Comprehensive Counseling Connections and its professional staff to deliver psychological services to me, or my children.*

B. *I authorize Comprehensive Counseling Connections to release information to my insurance company, as necessary, to obtain reimbursement for psychological services rendered.*

C. *I understand that I have been given an opportunity to read the Patient Bill of Rights, which is hanging on the waiting room wall, in accordance with New Hampshire state statute.*

Signature: _____ Date: _____

Optional: I authorize _____ to schedule or reschedule appointments and/or address billing questions on my behalf. CCC may release information to the identified individual, as minimally necessary for the tasks noted above. This release will be in effect unless otherwise cancelled in writing.

187 North State Street Concord NH 03301
Office: 603-856-8163 Fax: 603-856-8164

Comprehensive Counseling Connections, PLLC

KNOW YOUR BENEFITS (Client Copy)

As a part of the informed consent, and as a courtesy to our patients, CCC's billing company contacts your insurance carrier to obtain your benefit information (e.g., deductible, copay, coinsurance, and services that require a preauthorization or preapproval before your appointment). You will receive an 'Explanation of Benefits' (EOB) from your insurance carrier, after your first appointment. Your EOB will provide you with a breakdown of the application of your insurance coverage to the services that CCC has rendered.

I understand that CCC will bill my insurance as a courtesy, but out-of-pocket expenses (e.g., deductible, copay, coinsurance, unpaid claims, etc.) will be my responsibility. CCC strongly recommends that you contact your insurance company to verify that Comprehensive Counseling Connections, PLLC is in network and that the information your insurance company provided to our billing company is, indeed, accurate.

Insurance Benefits Verification Table:

Date of contact:		
Reference number for call:		
Name of contact representative:		
Session limitations:		
Yearly family deductible:	Yearly deductible satisfied:	□ Yes □ No
Yearly individual deductible:	Yearly deductible satisfied:	□ Yes □ No
Copay amount: $_____	Subject to deductible:	□ Yes □ No
Coinsurance: % _____	Subject to deductible:	□ Yes □ No

KNOW YOUR BENEFITS (Patient Signature Page)

I have reviewed the Know Your Benefits form with my practitioner. I acknowledge that I have received a copy of the Know Your Benefits form and affirm that I understand the terms set forth therein. Furthermore, I attest that CCC has provided, for my convenience, a table that I may use to record benefit information specific to my policy. I agree to discuss discrepancies with my practitioner and with the office manager immediately.

Signature:

Patient	Date:
Parent/Guardian	Date:
Witness/Practitioner	Date:

SERVICES "NOT COVERED" BY INSURANCE (Client Copy)

Insurers typically pay only for services which are delivered face-to-face with patients in the office, and our contracts with these insurance companies request that we notify patients in advance of any "noncovered" services. In addition to the information provided to you on the Information and Policy Statement, the list below is intended to provide further detail about the types of services your insurance plan typically will not cover or reimburse. Our standard fee for services that are not covered by insurance is $150.00 per hour.

Typical Services Not Covered:

1. Consultation/Collaboration (e.g., calling treatment facilities or schools to obtain information or arrange referral, contacts with social service agencies (DCYF), requested telephone contact in lieu of face-to-face meeting, etc.)
2. Court ordered evaluations, addressing subpoenas, preparation for court testimony, time allocated for court testimony, letters to lawyers, judges, probation officers, etc.
3. Educational testing
4. School consultation and team conferences (e.g., school IEP meetings, etc.)
5. HIPAA compliant email correspondence
6. Writing letters at patient request to various persons or agencies (e.g., social security administration for disability application, etc.)
7. Photocopying and releasing medical records for any purpose other than medically necessary treatment for other medical or mental health practitioners is 15 cents per page

Our Policy:

Please contact your practitioner to discuss the services that you are seeking. Your practitioner will generate an invoice describing the work that will be completed, the time allocated to the work, and the total out-of-pocket expense. Prior to rendering services, your practitioner will discuss the payment arrangements. Our policy requires payment in advance of service delivery.

SERVICES "NOT COVERED" BY INSURANCE (Patient Signature Page)

Acknowledgement:

I understand and have reviewed Services Not Covered by Insurance form. I acknowledge that I have received a copy of the form describing Services Not Covered by Insurance, and affirm that I understand the terms set forth therein.

Signature:

Patient	Date:
Parent/Guardian	Date:
Witness/ Practitioner	Date:

CANCELLATION AND RESCHEDULING POLICY (Client Copy)

Our office hours range from 8:00am-8:00pm, Monday-Friday. Should you need to cancel or change future appointments, a **24-hour** notice is **required,** except for **Monday appointments, which require cancellation on the Friday before** the appointment. Although we require only a 24-hour cancellation window, **we prefer a 48-hour notice**. You may call the office and leave a voicemail, at any time, to cancel your appointment; our phone system time stamps your call. Because your appointment time is reserved only for you and cannot be filled without sufficient notice, missed appointments or those cancelled less than **24-hours** in advance of your scheduled appointment, will be charged at the rate of **$60.00.** If you have a credit card on file, we will charge the fee on the same day; otherwise, we will collect payment from you at your next appointment. Please note, your insurance does not cover any portion of the $60.00 fee for missed appointments or those cancelled without sufficient notice. CCC may make exceptions on a case-by-case basis.

CANCELLATION AND RESCHEDULING POLICY (Patient Signature Page)

Acknowledgement:

I understand and have reviewed the Cancellation and Rescheduling Policy. I acknowledge that I have received a copy of the Cancellation and Rescheduling Policy and affirm that I understand the terms set forth therein.

Signature:

Patient	Date:
Parent/Guardian	Date:
Witness/ Practitioner	Date:

NOTICE OF PRIVACY PRACTICES

CCC strives to protect patient confidentiality; we are required, by law to maintain the privacy of patients' Protected Health Information (PHI). Federal legislation requires that we issue this official notice of our privacy practices and abide by the terms herein. If you have any questions about this notice, please ask your practitioner directly.

Those Subject to this Notice:

Any health care professional authorized to enter information into your record as well as employees, staff and other personnel at this practice, who may need access to your information must abide by this too. All business associates, such as representatives of managed care companies coordinating services, must follow these same privacy practices. Please understand that when personal health information is shared, only the minimum necessary information needed to accomplish this task will be disclosed.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization:

In most cases, CCC will not use or disclose your "protected health information" (e.g., name, date of birth) without your verbal or written authorization except for the reasons described below. Please note, if you provide authorization to use or disclose medical information, you may revoke that authorization, in writing, at any time. If you revoke authorization, we will, thereafter, no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we may have already made with your authorization. Furthermore, you agree and understand that we are required to document and retain a written record of the care we have provided you.

How We may Use and Disclose Medical Information Without Your Authorization:

There are limited circumstances where an authorization is not needed for disclosure of personal information. Most, but not every possible use or disclosure category are listed below. This notice applies primarily to information contained in your medical and billing records. More detailed and personal information contained in practitioners' "psychotherapy notes" are kept separately and are given an even greater degree of privacy and protection than the personal health information contained in your medical and billing records. As such, these would require written authorization even for the standard disclosure exceptions listed below.

For Payment:

We may use and disclose medical information about you without specific authorization, so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company, or a third party (e.g., we may release your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment). Insurance companies may review your medical record to verify services were rendered and were medically necessary in accordance with your insurance contract.

For Health Care Operations:

We may use and disclose medical information about you for health care operations, such as insurance audits of health care medical and billing records or clinical reviews to verify medical necessity for treatment and coverage.

Other Uses or Disclosures That Can be Made Without Consent or Authorization:

To avert serious threat to health or safety for you or others.
To report neglect or abuse of vulnerable populations (e.g., child/elder/functionally impaired).
To comply with court orders.

NOTICE OF PRIVACY PRACTICES

Your Rights Regarding Complaints Concerning Use or Disclosure of Your Health Information:

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services, whose address will be provided to you, at your request. All complaints must be submitted in writing.

Right to Request Restrictions

You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Comprehensive Counseling Connections is not required to automatically agree to a restriction you request, if the practitioner is otherwise obligated to release that information. Your request must be in writing and specifically state what information you wish to limit.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations

You have the right to request and receive confidential communications of private health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are a patient at this practice). Upon your request, this practice will send your bills to another address or arrange to call you only at work, instead of home.

Right to Inspect and Copy

Except in the most unusual circumstances, whereby, the practitioner may make a decision to restrict access to the medical record for the purposes of protecting patient information (e.g. court ordered evaluations, child custody cases), you have the right to inspect and/or obtain a copy of your private health information in the medical record. You also have a right to request statements detailing billing for services. This information will be maintained for the required length of time, as defined by the rules that govern record maintenance. Upon your request, your practitioner will discuss with you the details of the request process. Please see fee schedule.

Right to Amend

You have the right to request an amendment of private health information, as it is maintained in the record. Your practitioner may deny your request, if, in his/her opinion, the amendment would compromise the accuracy of your medical information.

Right to an Accounting

You generally have the right to receive an accounting of any disclosures of medical information. On your request, your practitioner will discuss with you the details of the account.

Changes to this Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future.

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NOTICE OF PRIVACY PRACTICES (Patient Signature Page)

Acknowledgement:

I understand and have reviewed the Notice of Privacy Practices. I acknowledge that I have received a copy of the Notice of Privacy Practices and affirm that I understand the terms set forth therein.

I am aware that the "Patient Bill of Rights" is displayed in our waiting room.

Signature:

Patient	Date:
Parent/Guardian	Date:
Witness/ Practitioner	Date:

CONFIDENTIALITY STATEMENT

Confidentiality Statement:

Comprehensive Counseling Connections will not release any information regarding your history or treatment without expressed permission from you or your guardian/parent. We will have you sign a release of information for our files. We are obligated to, and will, take every reasonable step, to protect your privacy as a standard of ethical and professional practice.

Exceptions:

There are several exceptions to this general policy; whereby, the state laws require that we break confidentiality. While the list below covers the major areas in which this can occur, the list does not cover every instance. By signing this form, you acknowledge the following:

A. Your receipt and understanding of these limitations, and
B. Your understanding of the right to ask your practitioner about the limits of confidentiality at any point during your treatment.

1) The law requires that practitioners report any suspicion of child abuse and/or neglect to the New Hampshire Division of Children, Youth, and Families (DCYF). Practitioners are also required to report suspicion of abuse or neglect of senior adults or vulnerable adults to the Bureau of Elderly and Adult Services (BEAS). We are mandated reporters. When we have a reasonable basis to suspect abuse or neglect of the populations mentioned above. We are required to report that information to the appropriate agency.

2) If anyone in this agency or your practitioner observes or comes to know of a serious threat or risk of danger to you or others, we may be required to act to protect you or them, thus, creating the possibility for disclosure of otherwise confidential information, in order to meet our legal duty.

3) If you authorize CCC to provide you with services, your insurance company has the right to obtain certain clinical information in order to process claims and determine medical necessity.

4) In rare instances, a court order may be issued at the request of an individual or agency seeking access to your clinical record. CCC and all providers must comply with court orders.

If you have signed CCC releases to provide information to others, you should remember that you may cancel these releases at any time; however, any information released prior to your withdrawal of permissions cannot be recovered.

CONFIDENTIALITY STATEMENT (Patient Signature Page)

Acknowledgement:

I understand and have reviewed the Confidentiality Statement. I acknowledge that I have received a copy of the Confidentiality Statement and affirm that I understand the terms set forth therein.

Signature:

Patient	Date:
Parent/Guardian	Date:
Witness/ Practitioner	Date:

INFORMATION POLICY STATEMENT

The Board of Psychology and the Board of Mental Health Practice Regulations, including the Mental Health Bill of Rights, requires all licensed mental health professionals to provide patients certain basic information. Also, to avoid confusion or misunderstandings, we are providing important information about our practice for your review and agreement. Please read it carefully and discuss any questions you have before signing below.

Cancellation/Rescheduling Policy:

Our office hours range from 8:00am-8:00pm Monday-Friday. Should you need to cancel or change future appointments, a **24-hour** notice is **required,** except for **Monday appointments, which require cancellation on the Friday before** the appointment. Although we require only a 24-hour cancellation window, **we prefer a 48-hour notice**. You may call the office and leave a voicemail, at any time, to cancel your appointment; our phone system time stamps your call. Because your appointment time is reserved only for you and cannot be filled without sufficient notice, missed appointments or those cancelled less than **24-hours** in advance of your scheduled appointment, will be charged at the rate of **$60.00.** If you have a credit card on file, we will charge the fee on the same day; otherwise, we will collect payment from you at your next appointment. Please note, your insurance does not cover any portion of the $60.00 fee for missed appointments or those cancelled without sufficient notice. CCC may make exceptions on a case-by-case basis.

Billing Policies and Procedures:

Payment is due at the time services are rendered, or as soon as we receive an Explanation of Benefits from your insurance company. Bank fees charged for returned checks will be added to patient account balance. If you are referred for assessment, CCC has additional paperwork for you to review and sign. CCC requires all assessment patients or their parents to sign a Fee Agreement Contract, which will clarify financial responsibilities and payment expectations. The following fees are for services that your practitioner or CCC may render, which are out-of-pocket expenses to you and/or claims that the insurance company denies.

Fees:

- Clinical Intake: $160.00 per hour
- Therapy Session: $130.00 per hour
- Clinical Emergencies: $150.00 per hour
- Other Clinical Services: $150.00 per hour

Other Clinical Services: This is a category of services that insurance companies will not reimburse. These services will be billed directly to the patient as an out-of-pocket expense. When a patient requests such services, their practitioner will discuss the associated cost and make payment arrangements before initiating any work. The following list is not exhaustive but covers a majority of CCC's nonbillable service requests: written documentation (e.g., court ordered reports, disability application reports, letters to providers, letters to schools); off-site meetings (e.g., court-ordered testimony; response to subpoena, IEP/504 meetings).

CCC practitioners, who work with children and families, welcome and encourage parents to schedule a separate session to discuss treatment goals, interventions, progress, etc. Parent meetings are billable to insurance. In contrast, when parents prefer to discuss their child's therapy over the telephone, the time spent on the phone is an out-of-pocket service. Your practitioner will explain the out-of-pocket expense and will make payment arrangements with the parent requesting the telephone contact, prior to scheduling the service.

INFORMATION POLICY STATEMENT

Regarding Your Insurance Policy:

Most managed care companies limit the number of sessions covered per year, which will be fully or partially reimbursed. Patients are encouraged to communicate directly with their managed care company about such limitations before starting treatment, as well as any concerns about the confidentiality of managed care records. Please be aware that we must release your diagnosis to your insurance company for reimbursement; if you do not want this information shared with your insurance company, we can discuss private-pay, which means that you agree that, at no time in the present or the future, will you seek reimbursement from your insurance company for sessions that you had while under said private-pay agreement.

Insurance companies provide coverage for services when they deem such services "medically necessary." Although this term varies by insurance company, "medically necessary" generally means that your condition interferes with your ability to satisfactorily perform important daily tasks, functions, or responsibilities. As your situation/condition improves, your practitioner will discuss with you when continued services may no longer meet your insurance company's definition of "medically necessary," which then means your insurance company will no longer reimburse for services.

Release of Information to Insurance Companies or Managed Care Organizations:

If you are billing health insurance or workman's compensation for your services at CCC, limited information must be released to your carrier and their managed care company (if applicable). In most cases, this involves a diagnosis and a verbal or written plan for your care. Many insurance policies authorize the insurance company to obtain or review copies of your medical record, and these may be disclosed without specific written consent by you.

Insurance Carrier Changes:

It is your responsibility to inform CCC of changes to your insurance carrier or to your insurance coverage.

Payment in Full or Applicable Deductibles and Copayments are Required at the Time of Service:

Unless other arrangements are made, your practitioner will collect your payment at each session. We send statements out on a monthly basis. After 30 days you will receive a letter alerting you if you have a balance due. A second letter will be sent at the 60-day mark, and finally, we will send you a statement, if your balance is 90 days in arrears. From that point, you will have two weeks to settle your account; otherwise, we will forward a statement of your account balance to our professional collection company.

Group Therapy:

Unlike individual treatment, confidentiality of group therapy is not privileged, and therefore is not protected by law. Group members must sign and abide by a written confidentiality agreement in order to participate in the group.

Emergency Coverage:

If you experience a psychiatric emergency after hours, please contact your practitioner directly. Each practitioner has a direct number to their office phone. If you cannot wait for your practitioner to call you back, you should call **Riverbend Community Mental Health, Incorporated, and Emergency Services @ 603.226.0817**; visit your local area hospital emergency room or dial **911**, or contact Riverbend Community Health, INC. on their 24-hour emergency services line at **1-844-7-HELP4U (1-844-743-5748)**.

If you are experiencing a psychiatric emergency and you **live outside of Merrimack County**, please contact your local community mental health center, your local hospital emergency room, or dial **911**.

INFORMATION POLICY STATEMENT (Patient Signature Page)

Acknowledgement:

I understand and have reviewed the Information Policy Statement. I acknowledge that I have received a copy of the Information Policy Statement and affirm that I understand the terms set forth therein.

Signature:

Patient	Date:
Parent/Guardian	Date:
Witness/ Practitioner	Date:

HIPAA EMAIL INFORMATION

1. HIPAA stands for *the Health Insurance Portability and Accountability Act.*

2. HIPAA was passed by the U.S. government in 1996 to establish privacy and security protections for health information.

3. Information stored on our computers is encrypted.

4. Most popular email services (e.g., Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.

5. **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**

6. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.

7. The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website- http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

8. CCC will not send personal health information using unencrypted email. However, should you and your practitioner decide to use CCC's HIPAA compliant email and/or video conference web portal, we will send a link to your personal email, so that you may sign up for the service.

AFTER HOURS EMERGENCY SERVICES

If you are experiencing a psychiatric emergency, and you are a resident of Merrimack County, you may call **Riverbend Community Mental Health Incorporated-Emergency Services @ 603.226.0817;** visit your local area hospital emergency room or dial **911**, or contact Riverbend Community Health, INC. on their 24-hour emergency services line @ **1-844-7-HELP4U (1-800-743-5748)**.

If you are experiencing a psychiatric emergency and you **live outside of Merrimack County**, please contact your local community mental health center, your local hospital emergency room, or dial **911**.

Suicide Prevention Lifeline: 1.800.273.8255 (TALK)

Crisis Center of Central NH (formerly Rape and Domestic Violence Crisis Center): 1.866.841.6229

Non-Emergency:

- Concord Hospital: 603.225.2711
- Concord Police Dept.: 603.225.8600
- Bow Police Dept.: 603.228.0511
- National Eating Disorders Association/ Info & Referral Helpline: 1-800-931-2237
- AA Hotline NH: 1.800.593.3330
- NA Hotline NH: 1.888.624.3578
- Crisis Center of Central NH (formerly Rape & Domestic Violence Crisis Center): Ofc (603.225.7376)

Comprehensive Counseling Connections, PLLC

CREDIT CARD AUTHORIZATION FORM (Patient Signature Page)

Date: _____

I _____authorize Comprehensive Counseling Connections to charge my credit card for services rendered and out-of-pocket expenses, as indicated.

Copay $_____USD

Coinsurance %_____

A coinsurance is the percentage of the billable rate that you will pay to CCC once you have satisfied your insurance deductible. Until you meet your deductible, your insurance will not pay any benefits; instead, they apply the charge toward your deductible. If you have additional questions about your insurance plan, please contact your carrier.

Credit Card Type: ____ Visa ____ Master Card

Credit Card #_____

Expiration Date: _____

3 Digit Security Code (located on the back of the card _____

Billing Address: _____

City: _____State: _____ Zip Code: _____

Name as it appears on the card: _____

Signature: _____ Date: _____

Do not write below, company use only.

_____

_____

_____