



# Welcome

Please complete and return the attached Intake Forms along with a Photo ID, Insurance Card or Authorization #. You may email these forms back to us or bring them to your appointment.

The following documents must be completed by each person receiving behavioral / mental health related services.

Please notify us within 24 hours if you need to cancel or reschedule your appointment, our contact information is located below.

## APPOINTMENT / SERVICE DEPOSIT

Appointment and Service Fees Deposit must be secured with a **Credit Card Authorization** for charges not covered by EAP/Insurance (co-pays, missed/canceled appointments, outstanding balances); or claims denied/rejected by Insurance/third Party Payer. The **Credit Card Authorization** will only proceed if the client fails to appear for a scheduled appointment (NO SHOW), Canceled or reschedules an appointment without a 24-hour cancellation notice, or when a claim is denied, rejected, or not covered.

A client with three (3) **No Show/Canceled Appointments** will no longer be permitted to schedule appointments in advance and may only be seen on a walk-in basis. Such fees are not covered by insurance, and the patient's responsibilities. Service may be terminated for late/canceled/missed appointments.

***Thanks for considering us to assist with your behavioral health needs.***



## FINANCIAL POLICY

### 1. SERVICE FEES:

- **Appointment Deposit: \$50** required to secure appointment, billable for No Show/Cancellations, or carried over to future appointments.
- **Diagnosis Interview/Intake: \$175 per unit** (60-90-minute session, billable in 15-minute increments+ Add-on \$65).
- **Individual, and/or Couple/Relationship Session: \$ 125** per unit (45-60-minute session, billable in 15-minute increments+ Add-on \$65).
- **Family and/or Group Session: \$ 70** per unit (45-60-minute session, billable in 15-minute increments).
- **Assessment/Testing:** fees vary depending on the types of assessment.
- **Review of Correspondence** (emails, letter, form, return messages): **\$35** (billable in 15-minute increments)..
- **Written Correspondence /Report:** \$150 per hour billable in 15-minute increments (1 hour minimum).
- **Completion of Medical Form:** \$25 per page, requested processed in 10-14 days.
- **Medical Record Request:** electronic copies \$6.50, hard copies \$3 per page, request processed in 10-14 days, and **released to patient only**.
- **Court Services:** \$150 per hour plus fees based on services requested.
- **Postage:** \$25shipping (if applicable), plus actual cost of postage.
- **Returned Checks: \$30.00**
- **Credit Card Processing: \$3.00**
- **Invoice Billing:** 5% interest charge (25% Annually) on accounts not paid within 30 days

Services Fees are due at the time of service; and cash, checks, credit cards and various insurance plans are accepted. If the patient's insurance provider is one with whom *Eclectic* is a participant, claims will be submitted with an understanding that the patient, not the insurance provider, is responsible for all charges. A 5% interest fee (25% Annually) will be charged monthly on account balances and noted on Patient Invoice. Accounts with 90-day balances shall be forwarded to a collection agency, and the patient shall be responsible for all related collection fees unless: 1) a *Payment Plan* has been approved by *Eclectic*; or 2) patient fails to honor *Payment Plan*. Additionally, the patient will be discharged with a referral list of local behavioral/mental health agencies.

### 2. APPOINTMENT / SERVICE DEPOSIT: Appointment and Service Fees Deposit must be secured with a **Credit Card Authorization** for charges not covered by EAP/Insurance (co-pays, missed/canceled appointments, outstanding balances); or claims denied/rejected by Insurance/third Party Payer. The **Credit Card Authorization** will only proceed if the client fails to appear for a scheduled appointment (NO SHOW), Canceled or reschedules an appointment without a 24-hour cancellation notice, or when a claim is denied, rejected, or not covered.

A client with three (3) **No Show/Canceled Appointments** will no longer be permitted to schedule appointments in advance and may only be seen on a walk-in basis. Such fees are not covered by insurance, and the patient's responsibilities. Service may be terminated for late/canceled/missed appointments.

### 3. LATE ARRIVAL: clients arriving for an appointment late will be given the option of being seen within the remaining appointment timeframe, if the schedule permits, or rescheduling with applicable **No Show/Canceled Appointments charges**.

### 4. INSURANCE: Insurance is an agreement between the patient and their insurance carrier/provider. While *Eclectic* may assist clients in filing insurance claims, the patient or their parent/guardian is the Responsible Party for all service fees incurred; and shall be responsible should the insurance provider deny or reject a claim for payment do to: 1) not efficacious (not medically or therapeutically necessary); 2) ineligible (services not covered by policy), policy expired, or not in effect; 3) patient submitted inaccurate, or incomplete information; 4) deductibles not met; or 5) failure to pay a claim within 30 days. Charges shall be assessed to Invoice Statement. If *Eclectic* receives payment thereafter, the patient shall be fully reimbursed.

A valid insurance card, provisions of insurance coverage, and notification of changes in benefits must be provided at the time of service. If a valid insurance card is not presented, or insurance benefits cannot be verified at the time of service, the patient must pay all applicable fees at such time. If *Eclectic* receives an insurance payment thereafter, the patient will be fully reimbursed.

Patient consent to **Release of Information to Insurance / Third Party Payer** is required to verify insurance coverage, benefits, and claims. See **Confidentiality / Privileged Communication / Record Policy** regarding information generally requested by Insurance/Third-Party Payers.

### 5. CO-PAYMENTS/DEDUCTIBLES: Co-payments, deductibles, and other fees not covered by Insurance/Third-Party Payers are due at the time of service; and must be secured by **Credit Card Authorization** (see policy).

### 6. NO INSURANCE/HIGH DEDUCTIBLE: **Clinical Care Packages** are available for individuals with No Insurance or High Deductibles. To be eligible, clients must select and secure the package with a **Credit Card Authorization** (see policy) on/before their first scheduled appointment. The credit card shall be charged in 3 monthly increments, beginning with the first scheduled appointment, regardless of scheduled or follow-up appointments. Clinical Care Packages will expire 12 months from the date of authorized signature. For individuals with High Deductibles, insurance claims may be processed noting payment received.

### 7. INVOICE STATEMENT: An **Invoice Statement** shall be sent monthly on accounts with outstanding balances (including claims denied/rejected by Insurance/third Party Payer) noting service/treatment date, description, and fee. If payment is not received within 15 days of the Invoice (except direct billing for No Show/Cancellation), the patient credit card will be charged, and a receipt of charges will be sent. A maximum of \$175 shall be charged monthly until all fees have been paid.

I understand that *Eclectic* will keep a copy of my credit card on file for future payments and charge all balances accrued monthly. I understand that if a payment is denied by the credit card on file, I will not be able to schedule any future appointments until the balance has been paid in full; that my account may be sent to an outside collection agency; and I will be discharged from the behavioral/mental health services.

I understand that I am responsible for notifying *Eclectic* of any changes in insurance coverage/information (provider's name, contact information, insurance coverage, etc.); and changes in patient information (name, address, phone, etc.) to ensure accuracy for Treatment, Payment, and Health Care Operations.

I understand that the information contained herein is considered a summary; and if I have questions or concerns about specific situations or any aspects of policy, I should discuss them with *Eclectic*.

My signature on the **Policy Acknowledgment & Informed Consent Form** affirms my receipt of this **Financial Policy**, understanding, and agreement to the conditions set forth therein.

This consent/authorization shall remain in effect until further notice; and it may be modified or revoked at any time. Revocation of consent may result in a loss of insurance benefits and services.



## CONFIDENTIALITY / PRIVILEGED COMMUNICATION / MEDICAL RECORD POLICY

**Confidentiality** is an ethical standard set forth by our profession, whereas *privileged communication* is a legal right that protects clients from the disclosure of **Protected Health Information** (PHI) without their informed consent. *Privacy*, according to the Health Insurance Portability and Accountability Act (HIPAA) regulation, is an individual's right to control access and disclosure of their PHI.

HIPAA requires that information provided by an individual to health care providers including notes and observations about their health will not be used for purposes other than treatment, payment, health care operations or for the specific purposes described in the Privacy Rule. The Privacy Rule does not prevent health care providers from consulting with other health providers regarding client/patient treatment.

**Limits of Confidentiality.** There are situations where **Eclectic Cognitive Behavioral Center (Eclectic)** may be required or permitted to disclose information without the client's authorization or consent. These legal exceptions include:

- **Duty to Warn and Protect:** When serious and foreseeable harm to client or others is evident, **Eclectic** is required to notify the appropriate legal authorities; warn the intended victim; and make reasonable attempts to notify the client's family.
- **Abuse, Neglect or Exploitation of a Child or Vulnerable Adult:** When abuse, neglect or exploitation of a child or vulnerable adult is evident or suspected **Eclectic** is required to report such information to the appropriate social service and/or legal authorities. (Vulnerable adult is defined as a person who is 18 years of age or older who has a substantial mental or functional impairment.)
- **Prenatal Exposure to Controlled Substances:** When a client discloses that he/she has exposed a fetus or child to a controlled substance that is potentially harmful during pregnancy, **Eclectic** is required to notify the appropriate legal authorities.
- **Court Orders / Legal Disclosure:** When information is requested by a valid subpoena, court order, or required by law **Eclectic** is required to release such information to the appropriate legal authorities. **Eclectic** will make every legal attempt to protect clients' PHI.
- **Minors/Guardianship:** Parents or legal guardians have the right to access records of non-emancipated minor clients. Thus, when a parent or legal guardian of a non-emancipated minor, request information, **Eclectic** is required to release confidential information to the parent or legal guardian making the request.
- **Insurance/Third Party Payer:** When you or the **Responsible Party** authorize payment of benefits by an Insurance company and other third-party payers **Eclectic** may be required to release confidential information for payment of services e.g. name, date of birth (DOB), social security #, services rendered, dates/times of services, diagnosis/description of symptoms, and treatment goal/plan.

**Eclectic** respects each client's rights to privacy. To the extent required by law, clients are informed, involved in the disclosure decision-making process, and provide Informed Consent before confidential information is disclosed. When circumstances require the disclosure of confidential information, only essential information is revealed.

**Protected Health Information (PHI)** refers to any information that identifies an individual, and relates to at least one of the following:

- The individual's past, present or future physical or mental health.
- The provision of health care to the individual.
- The past, present or future payment for health care.

Information is deemed to identify an individual if it includes either the individual's name or any other information that could enable someone to determine the individual's identity (e.g., address, DOB, age, Social Security number, e-mail address).

**Medical Records.** In an effort to protect confidentiality and privileged communication, notes taken during a session or any interaction with a client are referred to as *Psychotherapy Notes*, which are summarized and transposed into a typewritten/electronic format that become a part of the *Patient Medical Record*. Once transposed, written notes are shredded, and only typewritten/electronic notes are maintained, with the exception of *Psychotherapy Notes* which are maintained separately from patient medical and billing records and not released to anyone. *Patient Medical Records* are maintained for seven (7) years after the client's last visit, and seven (7) years past the 18<sup>th</sup> birthday of minors. After which, the *Patient Medical Record* is incinerated. Request for *Patient Medical Record* will be made available in 14 days, following the patient's signed authorization or consent to the Release of Information, and will only be made available to the patient. See **Financial Policy** regarding fees for copies of *Patient Medical Record*. While patients have a right, with few exceptions, to inspect, review, and receive a copy of your medical records and billing records, they do not have such rights to *Psychotherapy Notes*.

The **Privacy Rule** defines *Psychotherapy Notes* as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record. See 45 CFR 164.501.

**Client Contact/Communication.** I understand that telecommunication mediums (phones, text messaging, emails, postal mail, etc.) are not a secure way of preserving confidentiality, nor a reliable method of contacting clients or **Eclectic** in crisis/non-crisis situations. I consent to **Eclectic** contacting me via the mediums noted on the **Policy Acknowledgment & Informed Consent Form**.

I understand that protected health information is collected and stored on databases, and that at all times my privacy is treated with the highest regard. I understand that **Eclectic** will make reasonable efforts to disclose only that information which is necessary for securing payment, conducting standard health care operations, and that which is required by law. I understand that the information above is considered a summary; and if I have questions or concerns about specific situations or any aspects of this or other policies, I should discuss them with **Eclectic**.

My signature on the **Policy Acknowledgment & Informed Consent Form** affirms my receipt of this **Confidentiality / Privileged Communication / Medical Record Policy**, understanding, and agreement to the conditions set forth therein.

This consent/authorization shall remain in effect until further notice; and it may be modified or revoked at any time. Revocation of consent may result in a loss of insurance benefits and services.



**INSURANCE / THIRD PARTY PAYER  
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)  
(Valid Insurance Card Required)**

I understand that:

- Insurance is a contract between the patient and the provider. While Eclectic may assist clients in filing insurance claims, the patient or their parent/guardian is the Responsible Party for all service fees incurred; and shall be responsible should the insurance provider deny or reject a claim for payment do to: 1) not efficacious (not medically or therapeutically necessary); 2) ineligible (services not covered by policy), policy expired, or not in effect; 3) patient submitted inaccurate, or incomplete information; 4) deductibles not met; or 5) failure to pay a claim within 30 days. Charges shall be assessed to Patient Invoice. If *Eclectic* receives payment thereafter, the patient shall be reimbursed.
- Patient consent to **Release of Information to Insurance / Third Party Payer** is required to verify insurance coverage, benefits, and claims. See **Confidentiality / Privileged Communication / Record Policy** regarding information generally requested by Insurance/Third-Party Payers.
- A valid insurance card, provisions of insurance coverage, and notification of changes in benefits must be provided at the time of service. If a valid insurance card is not presented, or insurance benefits cannot be verified at the time of service, the patient must pay all applicable fees at such time. If *Eclectic* receives an insurance payment thereafter, the patient will be reimbursed.
- The provision of treatment requires communication of PHI among Eclectic's administrative staff, and my insurance / third-party payer. Such PHI will be limited to the provisions of insurance benefits and will be accessible only to persons necessary is to determine payments and/or insurance benefits.
- Protected Health Information (PHI) may include name, DOB, social security #, services rendered, dates/times of services, diagnosis/description of symptoms, treatment goal/plan and prognosis, etc.; and that authorization to release PHI to my insurance /third part payer shall remain valid 365 days after the last date of my treatment; or I revoke this release.
- *Appointment and Service Fees Deposit* must be secured with a *Credit Card Authorization* for charges not covered by EAP/Insurance (co-pays, deductibles, missed/canceled appointments, outstanding balances); or denied/rejected by Insurance/third Party Payer.
- Parent/Guardian Permission written consent is required for minor patients with the exception of patients aged 18 years older and, and/or emancipated youth. Exceptions are made in circumstances wherein federal, or state law allows minors to seek certain treatment or services without parental consent.

I consent/authorize **Eclectic Cognitive Behavioral Center** to send and/or receive Protected Health Information (PHI) to/from the insurance company(s) and/or other third-party payers noted above for the purpose of receiving payment for services.

My signature on the **Policy Acknowledgment & Informed Consent Form** affirms my receipt of this **Insurance / Third Party Payer Consent to Release Information Policy**, understanding, and agreement to the conditions set forth therein.

This consent/authorization shall remain in effect until further notice; and it may be modified or revoked at any time. Revocation of consent may result in a loss of insurance benefits and services.

(REVIEW OTHERSIDE Revised: 11/2023)