PATRICIA A. GOODING, MS, LPCC, MFT --CLIENT DATA AND BILLING INTAKE FORM

CLIENT INFORMATION:

LAST NAME _____ HOME PHONE (____)_____
FIRST NAME _____ MID INIT___ WORK PHONE(_____)_____
STREET ADDRESS _____ CELL PHONE (___)_____
CITY, STATE, ZIP _____ EMAIL: _____
DOB _____ GENDER: M / F EMPLOYER/SCHOOL _____
MARITAL STATUS: □ SINGLE □ MARRIED □ OTHER

INSURED OR PARTNER'S INFORMATION:

LAST NAME _____ EMPLOYER _____
FIRST NAME _____ MID INIT___ WORK PHONE(_____)_____
STREET ADDRESS _____ HOME PHONE (____)_____
CITY, STATE, ZIP _____ RELATIONSHIP TO
DOB _____ _____ CLIENT_____

It may be necessary to discuss treatment with the following people for continuity of care:
EMERGENCY CONTACT _____
RELATIONSHIP TO CLIENT _____

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CASH PAYING CLIENTS MAY SKIP THIS SECTION

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INSURANCE INFORMATION: (Provide insurance ID card to be copied or provide the following)
PRIMARY Insurance Company _____
Phone: (____)_____
Policy Number _____ Group Number _____
Name of Policy Holder_____ Policy Holder ID# _____
Policy Holder Phone Numbers: Work _____Home _____
Employer _____

Client (or guardian) Signature _____ Date _____

INFORMED CONSENT

Thank you for choosing Patricia A. Gooding, MS, LPCC, MFT. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Patricia A. Gooding, MS, LPCC, MFT, has earned a Bachelor of Arts Degree in Management from the University of Redlands, Redlands California and a Masters Degree in Mental Health Counseling from Wright State University. She is licensed by the State of Ohio as a Licensed Professional Clinical Counselor and a Marriage and Family Therapist. She has nearly thirty years of clinical experience in treating children, adolescents, adults and families using individual and family therapy. Pat practices standard cognitive behavior therapy for many conditions although other treatment approaches are frequently used geared to the person or condition.

Treatment practices, philosophy and plan limitations and risks (such as how others may respond to changes you make as a result of therapy) will be discussed with you today. If you have questions or feel any of these areas are not adequately addressed, please ask for clarifications during your intake session to ensure your understanding.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service, treatment plan and prognosis, if requested) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Ohio State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and g)when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Pat will provide standard counseling and support to the client or the client's family as necessary following those emergency services.

Signature(s)_____Date:_____

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or at least 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. We ask that every client authorize payment of medical benefits directly to Patricia A. Gooding, MS, LPCC, MFT.

Lastly, if you need to cancel or reschedule an appointment, please give at least 24 hours advance notice, otherwise you will be billed. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask. You may have a copy of this form if requested.

Signature(s)_____Date_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)_____Date_____

We may need to contact you for administrative reasons in the course of providing counseling. Please check the best way to contact you:

- ☐ Text message to your cell phone?
- ☐ e-mail?
- ☐ Phone?
- ☐ Mail to your home address?

Please let me know if you do NOT want me to contact you by any of the above methods.

Signature(s)_____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ may be treated as a client by Patricia A. Gooding. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)_____Date_____

INSURANCE ASSIGNMENT AGREEMENT
ANNUAL SIGNATURE

Patricia A. Gooding, MS, LPCC

42 E. Rahn Road, Ste 102
Kettering OH 45429-5459

Phone: 937-361-5987
FAX: As Scheduled

Client Name _____

Responsible Party (If client is minor)_____

Health Insurance Co._____

I request that the payment under _____(Insurance Program) be made on my behalf to Patricia A. Gooding, LPCC (the Provider), for services furnished. I hereby authorize the Provider and/or agents to release information about me (and the client) to the extent necessary to process claims for payment for services rendered. Necessary claims information will include identifying data, the diagnoses and the services being furnished, and may be submitted either in written form (HCFA 1500) or electronically, depending on the compatibility of the insurance carrier system.

Client Signature _____ Date _____
(Parent or Guardian for child)

HIPPA 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.

Effective date: April 14, 2003

Patricia A. Gooding, MS, LPCC, MFT has been and will always be totally committed to maintaining clients' confidentiality. She will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT. We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT. Information needed to verify insurance coverage and/or benefits with you insurance carrier, to process claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for you insurance.

HEALTHCARE OPERATIONS. We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require you consent. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: information you and/or your child or children report about physical or sexual abuse; then by Ohio State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of/or schedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. Please indicate your choices on the Notice of Informed Consent.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under some circumstance we may deny your request to inspect and copy. I may suggest a summary letter including: diagnosis, dates of service and summary of progress. If you ask for a copy of any information, we may charge a reasonable fee for the costs of preparing any summary letter/information, copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You have a right to an accounting of disclosures, if any, which is a list of certain disclosures such as child or elder abuse, disclosures related to suicidal or homicidal threats, and disclosures to the U. S. Dept. of Health and Human Services to evaluate compliance.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.