WOL Word of Life
Behavioral Health Services

Right now everything is about Life

Child, Adolescent, and Family Counseling
524 Georgia Ave., Suite #6
North Augusta, SC 29841

Phone: 803-474-5129
Fax: 803-426-8650

Today's Date: ________________

Dear Consumer:

Welcome to our office! Thank you for entrusting us with your mental health and emotional wellbeing. It is important that you understand our office's policies. We are a small mental health practice specializing in the personal touch. In any appropriate way, we will serve you and help you meet your needs.

APPOINTMENTS

_________________________ has been referred to our office by _________________________
Please note: We will schedule you for therapy once all paperwork has been completed for intake and the initial assessment has taken place, unless other arrangements have been made.

You will find in this packet forms regarding patients, parents/guardians, your child and possibly affiliates of the respective school system. Please fill in all blanks and indicate 'none' or N/A for questions that do not apply.

Your appointment time is reserved exclusively for you. We do not double book appointments in this office. We ask that you consider the importance of making scheduled appointments as your primary goal for treatment. Please know that our commitment is to provide service excellence, and not keeping your own appointments may slow that process. If you miss three (3) consecutive appointments, without any notice or contact with your therapist, your case will be closed.

Please initial confirming that you have read the above statement: ____________________

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
& OTHER INFORMED CONSENTS

______ **RELEASE OF INFORMATION**
I, the legally responsible person, authorize Word of Life Behavioral Health Services to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical services to third party payers and/or health practitioners.

______ **FEE ASSESSMENT**
I, the legally responsible person, thereby assume responsibility for payment of costs for services provided by Word of Life Behavioral Health Services.

______ **AUTHORIZATION OF DIRECT PAYMENT**
I, the legally responsible person, hereby authorize and direct payment of medical benefits to Word of Life Behavioral Health Services.

______ **NON-COVERED SERVICES**
I, the legally responsible person, understand that in the event that my health plans determine a service to be not covered, I will be responsible for the complete charge.

______ **UNPAID SERVICES**
I, the legally responsible person, assume responsibility for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services to avoid collection from me (legally responsible person) on behalf of the client's treatment/habilitation.

______ **PRIOR AUTHORIZATION**
I, the legally responsible person, understand that services rendered may require prior authorization through my health insurance. I understand that failure to inform Word of Life Behavioral Health Services of all insurance(s) in which the client receives benefits, may result in the inability to obtain approval for services rendered.

______ **PRIMARY/SECONDARY INSURANCE**
I, the legally responsible person, understand SC Healthy Connections Medicaid is billed for the services provided as **secondary** health insurance. I understand that failure to inform Word of Life Behavioral Health Services of all health insurances by which I receive benefits, it may result in denial of services covered, and I will be responsible for the assessment fees.

______ **MEDICAL SIGNATURE ON FILE**

I request that payment of authorized medical benefits be made either to me or on my behalf to Word of Life Behavioral Health Services for any services rendered. I authorize any holder of medical information about me to release to the centers for Medicaid and Private Insurance services and its agents any information needed to determine these benefits or the benefits payable for related services.

______ **INFORMED CONSENT FOR THE GRIEVANCE PROCEDURES**

I, the legally responsible person, understand that the client has the right to disclose any grievances that he/she/they may have as it relates to the agency. I, the legally responsible person, understand that the client will provide a description of the assistance that he/she/they will be provided. I the legally responsible person, understand that he/she/they will be provided the results of his/her/their grievance. I, the legally responsible person, understand that he/she/they will be given a chance to dispute the results of his/her/their grievance if the findings are not to his/her/their satisfaction.

______ **INFORMED OF CLIENT'S RIGHTS**

I, the legally responsible person, and client understand and have been informed/received a copy of the Client Rights handbook. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

______ **SOCIAL INTEGRATION**

I, the legally responsible person, give Word of Life Behavioral Health Services permission to allow the client to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. The client shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 ©.

_____ **SEARCH AND SEIZURE**

I, the legally responsible person, understand that each client shall be free from unwarranted invasion of privacy. However, I, a legally responsible person, understand that searches by staff from WOL, LLC, the legally responsible person, also give permission to the agency to perform random planned or unplanned searches and seizures on the client belongings, or property in his/her possession. I understand that each search will be documented to include; scope of search, reason for search, procedure followed in the search, description of any property found and an account of the disposition of seized property.

_____ **SUSPENSION AND EXPULSION FROM SERVICES**
I, legally a responsible person, understand that if the client does not comply with the rules outlined by the agency and becomes a possible threat to others served within this agency, he/she may be possibly suspended or excluded from services. I understand that this would be the agency's last resolution before assessing the client to see if he/she meets the criteria to discharge. (However, if it results in discharge the agency will follow its due procedures before exhausting all other means.

_____ **GOVERNOR'S ADVOCACY COUNCIL**
I, the legally responsible person, understand a written summary of clients shall be made available to each client and legally responsible person. I have been informed of his/her rights (Governor's Advocacy Council) that the statewide agency designated under federal and state law to protect and advocate the rights of the person.

_____ **ADMISSIONS INTO SERVICE AGREEMENT**
I understand that the client and the legally responsible person shall be informed either upon admission or entry into service.

_____ **INFORMED CONSENT FOR THE AGENCY RIGHTS**
I, the legally responsible person, understand the rules that the client is expected to follow and possible penalties for violations of the rules.

_____ **INFORMED CONSENT FOR CONFIDENTIALITY**
I, the legally responsible person, understand that the agency will follow policy as it relates to protecting the client's rights regarding disclosure of confidential information as delineated in G.S. 122C-52 through G.S. 122C-56.

_____ **CONSENT REGARDING TREATMENT**
I, legally responsible person, give permission to Word of Life Behavioral Health Services to obtain a copy of client's treatment/habilitation and or/other information that relates to the client in order for the agency to adequately serve the client.

_______________________________ _______________
Client Signature Date

_______________________________ _______________
Legally Responsible Person Date

_______________________________ _______________
Witnessed By Date

INFORMED CONSENT RIGHTS

I __________________________ (the legally responsible person) and _______________________ (client's name) understand and have been informed and received a copy of the Client's Rights Handbook. I understand the consent forms and valid unless the client or legally responsible person chooses to withdraw the consent.

_____________________________________ _________________
Client Signature Date

_____________________________________ _________________
Legally Responsible Person Date

_____________________________________ _________________
Witnessed By Date

CONSENT TO TREATMENT

1. I_________________________ (client's name or legal guardian) of _________________________give permission for Word of Life Behavioral Health to give me Mental Health treatment.

1. I allow Word of Life Behavioral Health to file for insurance benefits to pay for the care I receive.

   I understand that:

- **Word of Life Behavioral Health** will have to send my medical record information to my insurance company.
- I must **pay** my share of the costs.
- I must **pay** for the cost of these services if my insurance does not pay or I do not have insurance.

1. **I understand that:**

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

_________________________________ _______________
Client Signature Date

_________________________________ _______________
Parent or Guardian Signature Date
(For children under 18)

_________________________________ _______________
Witnessed By Date

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Phone: 803-474-5129 | 524 Georgia Avenue North Augusta, SC 29841 | Fax: 803-426-8560

Name: __________________________________ DOB: _____________ Sex: ______
Address: ____ SSN: ________________________
City, State, Zip: ______________________________________ Race: _________________
Phone Numbers: 1. _________________ **2.** ___________________ **3.** ___________________
Marital Status: S M D W **Employees:** Y or N **Student:** Y or N
Employer/School Name: __________________________________ **Phone:** _______________
Address: ____
Financially Responsible Person (If different from Client): ___________________________
SSN: ________________ **Sex:** M or F **Relationship to Client:** ______________________
Address: ___________________________ **Phone:** _________________
Emergency Contact: ________________________ Relationship **to Client:** _______________

<u>INSURANCE INFORMATION</u>
Primary: __________________ **Policy/Group#**______________ **Phone:** _________________
Address: ____________________________ **Employer:** __________________________
Relationship to Client: ________________ **DOB:** ______________ **SSN:** ________________
Secondary: _________________ **Policy/Group#**___________________ **Phone:** ___________
Address: ___________________________ **Employer:** ____________________
Relationship to Client: ___________________ **DOB:** ______________ **SSN:** _____________
Primary Care Provider: _________________________ **Phone:** ________________________
Address: ________________________________ Phone: ____________________________

May our office contact your Primary Care Provider? Y or N

I hereby authorize release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to this practice for the services rendered. I understand I will be responsible for the difference between charges and insurance payments (i.e., Medicare allowances, managed care fee schedules, deductibles.)

SIGNATURE: _____________________________ Date: _________________________

Do you consent to have anyone participate in your or your child's treatment?
If so, who? ____

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FEES AND FINANCIAL POLICY

1. An initial office visit (one hour) is $150 for adults and children. Subsequent office visits are based on length and complexity of issues but may range from $85-$135. If you have private insurance and an un-met deductible, the cost of service is $75. Please come prepared to pay for your first visit and we will reimburse you as soon as we receive payment from your insurance company.

1. Because insurance plans differ widely as to what they provide for mental health, please check with your insurance company ahead of time to see what part of the fee they will cover.

1. If you pay a copay, we will ask for it at the time of your appointment. Otherwise, we will expect payment in full if you have made no other arrangements with us in advance. Deductibles are your responsibility. At the first of the year, or until deductibles are met, we ask that you pay up front and in full unless other arrangements have been made ahead of time.

1. From time to time, WOL is able to make arrangements with your insurance company even though it is out of network. Please remember that whatever your insurance doesn't cover remains your responsibility.

1. We accept cash, personal checks, money orders, Visa and MasterCard.

1. We will file your insurance as a courtesy for you and bill you for any unpaid balances. If after a reasonable amount of time and your bill still remains unpaid, we will seek other means of collecting the money from you. If you are paid directly by your insurance company, we will request payment in full each visit. You may contact our office if you have a question about your bill or need to make arrangements for monthly payments.

1. All your insurance coverage cards, both primary and secondary, must be presented at the time you return your packets, so we can work on any insurance issues prior to your first visit. Please inform us of any insurance changes.

1. We need accurate information from you. We need your full legal name, a working telephone or cell phone numbers and accurate address at all times. Please notify us at any time if you change your name, phone number, address or insurance company.

Fees and Financial Policy Section: ___________________ (Please Initial)

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Consumer Orientation

Please indicate that you have received and read the client/consumer oration book.

Signature: ___________________________________ Date**:** __________________

POLICIES FOR SPECIAL CIRCUMSTANCES

1. WOL provides Diagnostic Assessment and counseling. WOL does not mediate in legal or divorce situations nor complete custody evaluations. If for any reasons you require an attorney or refereed here by an attorney, the expenses for legal testimony or documents will be billed directly to him/her.

1. WOL doesn't perform formal psychological testing nor does WOL complete disability evaluations. We will send copies of your clinical notes, if requested, to a referring Physic Agency, or Social Services. We will bill for any time taken to complete letters or forms for your insurance company attorney or any other third party, once we have permission.

1. Should interpretive services be needed, notify our office when returning your new patients documents.

I have read and understand the policies stated above and agree to abide by them.

Signature: ___________________________________ Date: ___________________________

HIPAA DISCLOSURE AND RULES FOR OUR PATIENTS

The covered entry in this statement refers to our office only, this is a personalized statement and should not be confused with any other HIPAA statements you have read in other behavioral health offices.

The HIPAA privacy rule organizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information concerning their public health mission. The rule also recognizes that public health reports made by covered entities are important means of identifying threats to the health and safety of the public at large and as individuals. Accordingly, the rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

Privacy and confidentiality as it pertains to our patients: Privacy is about who has the right to access personally identifiable information. This covers all individually identifiable health information in the hands of covered entities, regardless of where the information is or has been electronic form.
Privacy Standards are as follow:

1. Limit the non-consensual use and release of private health information.
2. Give new patients right to access their medical records and to know who else has accessed them.
3. Restrict most disclosure of health information to the minimum needed for the Intended purpose.
4. Establish new criminal and civil sanctions for improper use of disclosure.
5. Establish new requirements for access records by researchers end others.

The five basic principles of privacy are:

1. Consumer Control: The regulation provides consumers with critical new rights to control the release of their medical information.
2. Boundaries: With few exceptions an individual’s healthcare information should be used for medical purposes only, including treatment and payment.
3. Accountability: Under HIPAA for the first time, there will be specific federal penalties if a client's right to privacy is violated.
4. Public Responsibility: The new standards reflect the need to balance privacy protections with public responsibility to support such national priorities as protecting public health, conducting medical research, improving the quality of care, and fighting health care fraud and abuse.
5. Security: It is the responsibility of organizations that are entrusted with health information to protect it against deliberate or inadvertent misuse of disclosure.

The Privacy Rule permits our office to disclose protected information, without authorization to public health authorities who are legally authorized to receive special reports for the purpose of preventing or controlling disease, injury, or disability. This would include. for example, the reporting of a disease or injury; reporting vital events, such as birth or defects; and concluding public health surveillance, investigations or inventions. Any covered entity may, to the direction of the collaboration with a public

health authority. Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes.

A “public health authority” is an agency or authority of the United States government, a slate, a territory in a political subdivision of a State or territory, or Indian tribe that is responsible for public health mailers of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with a public health agency. Examples of a public authority in Slate and local health departments are: The Food and Drug Administration, The Centers for Disease Control and Prevention, and The Occupational Safety and Health Administration.

As a general rule our office is required reasonably, to limit the protected health information disclosed for public health purpose to the minimum amount necessary to accomplish the public health purpose. We are not required to a minimum necessary determination for public information disclosures that are made pursuant to individuals’ authorization, or for disclosures that are made pursuant to individuals’ authorization, or for disclosures that are requiring other law. For routine and recurring public disclosures such as a release of information to a doctor, school institution or other professional, we will develop standard protocols, as a part of our minimum necessary policies and procedures, address the types and amount of protected health information that may be disclosed for such purposes.

Other public activities; The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities, this allows covered entities such as our medical office, to disclose protected health information, without authorization, to such personal entities for the public health activities discussed below:

1. Child abuse or neglect; our office may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to a public health authority or appropriate government authority that is authorized by law to receive such reports. For instance, social services department of a local government might have the legal right to receive reports of child abuse or neglect in which case, the Privacy Rule would permit a medical office or any covered entity to report cases to that authority without obtaining authorization. Likewise, a covered entity can report such cases to the police department when the police department is authorized by law to receive such reports.
2. Persons at risk of contracting or spreading a disease: a covered entity may disclose provider health information to a person who is at risk of contracting or spreading a disease or condition. No other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations.
3. Workplace medical surveillance: a covered health care provider who provider healthcare service to an individual at the request of the individual's employer, or provides the service in a capacity of a member of the employees workforce may disclose the individual’s protected health information to the employer for the purpose of workplace medical surveillance or the evaluation of workplace illness and injuries to the extent the employer needs that information to comply with OSH, the Mine Safety and Health Administration, or the requirements of state laws having similar purpose. The information disclosed must be limited to the provided findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written

notice that the information on will be disclosed to his or her employer or the notice must be at the worksite if that is where the service is provided.

There are three situations when the parent would not be the minor's personal representative under the Privacy Rule, they are:

1. When the minor is the one who consents to care and the consent of the parents is not required under State or other applicable law.
2. When the minor obtains care at the direction of a court or person appointed by the court.
3. When, to the extent that, the parent agrees that the minor and the healthcare provider may have confidential relationship, even with these exceptional situations, the parent may have access to the medical record of the minor related to this treatment when State or other applicable law requires or permits such parental access. Parental access would be denied when State or other law prohibits their access. If the State or other law is silent on a parent's right of access in cases, that licensed healthcare provider may exercise his or her professional judgment to the extent allowed by law to grant or deny parental access to the minor's medical information.

As is the case with respect to all personal representatives under the Privacy Rule, Word of Life Behavioral Health, LLC reserve the right to withhold a parent to a child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

As a final note, we will take all measures to ensure privacy and security while you are a client with our office. Some of the measures we take include: turning our computer screens, turning charts over so as not to see the name, keeping our scheduling book in an area where only we can read it and not saying a patient. Client's full name aloud for everyone to hear it, we will do this for your privacy and securities as well as every other patient in our office so please do not ask us to compromise our rules just make things easier for you/anyone. By this we are asking that you do not look at our scheduling book or our computer screens and, please do not go through other patients' charts that are sitting on the front desk.

Please sign and date **after you have read this statement.** If you have any questions, please ask us and we will be happy to help you.

Signature: ____ Date: ___________________________

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Phone: 803-474-5129 524 Georgia Avenue Fax: 803-426-8650
North Augusta, SC 29841

RELEASE OF INFORMATION

Name: ______________________________ Date of Birth: ____________________
Social Security Number: ____________________

I hereby authorize Word of Life Behavioral Health to:

_____ Release records to: Print Name and Address of person/agency:
_____ Receive records from: ______________________________
_____ Share Information: ______________________________
(to include written and verbal communication) (one agency/person per release)

Please include the following:

___Psychological Eval	___Lab Results	___Hospital Records
___Psychiatric Eval	___Service Plan	___Continuity of Care
___Clinical Notes	___Correspondence	___Re-disclosure
___Intake/Assessment	___School Records	___Other
___Discharge Summary	___School Testing	
___ Drug and Alcohol Treatment	(including Psycho-ed, Speech, Hearing IEP, SNAPS)	

This consent shall be valid for: ______________________________ (not to exceed one year)

I acknowledge Word of Life Behavioral Health has not conditioned my treatment on signing this authorization and that I may refuse to sign this authorization if I choose to. I understand that Word of Life Behavioral Health cannot deny or refuse to provide treatment, payment or eligibility for benefits on my refusal to sign. Once information is disclosed in regards to this signed authorization, I understand that the HIPAA privacy law protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from re-disclosing it. When Word of Life Behavioral Health's office does disclose mental health and developmental disabilities information protected by state law or substance abuse treatment information prohibited except as permitted or required by law.

I understand I may revoke this authorization at any time except to the extent that action has been taken in reference to it. If I revoke the authorization, I must do so in writing by submitting a signed revocation statement to Word of Life Behavioral Health at 524 Georgia Avenue, North Augusta, SC 29841.

Client Signature: ______________________________ Date: ____________________
Signature: ______________________________ Date: ____________________
_______Parent ________Guardian ______Legally Responsible Person
(Required for all clients under 18, guardian must show proof of guardianship)

TO BE COMPLETED IF CLIENT IS PHYSICALLY UNABLE TO SIGN
I, the undersigned, do verify that the client is physically unable to sign this consent form and that he/she wishes to release records described above, understands the nature and purpose of the release, and freely gives his/her consent for the release of information.

Witness: ______________________________ Date: ____________________

No Show, Late, & Cancellation Policy

Description

"No Show" - any client who fails to arrive for a scheduled appointment.
"Late Cancellation" - any client who cancels an appointment less than 24 hours before their scheduled appointment.
"Late Arrival" - any client who arrives 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment "no shows" and "late cancellations". WOL's goal is to provide excellent care to each client in a timely manner. If it is necessary to cancel an appointment, clients are required to call and/or leave a message **at least 24 hours** before their appointment time. Notification allows the practice to better utilize appointments for other clients in need of prompt care.

Procedure

All clients are notified of the appointment "No Show, Late, & Cancellation Policy" at the time of scheduling.

- Appointments must be canceled at least 24 hours prior to the scheduled appointment time.
- In the event a client arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future session, if available.
- In the event a client has incurred three (3) documented "no shows" and/or "late cancellations", the client may be subject to dismissal from WOL. The client's chart is revised and dismissals are determined by the provider.
- A **$60 fee** will be charged for all **private insurance** and **self-pay** clients for "late cancellations"/ "no shows" with no expectations.

______________________________________ ______________

Signature of Client/Legally Responsible Person Date