Trussville Family Counseling

Terry Mashburn, LPC * Brenda Mashburn, LMFT * Stephen Long, LPC

Donna Marsh, LPC * Nikki O'Dell, LCSW

PATIENT INFORMATION **DATE:** _____

Last Name _____ First Name_____ M.I ___

Male ___ Female ___ Marital Status: Married ___ Single ____ Divorced ___ Widowed ___

Street Address _____ City _____ State ___ Zip _____

Social Security # _____Date of Birth _____

Cell Phone _____ Home Phone _____ Email _____

Employer _____Job Title _____

Spouse/Parents Name _____Spouse/Parents Employer_____

Children's Name & Ages _____/_____/_____

Person Responsible for Payment (if not the above)

Last Name _____ First Name _____ M.I ___

Street Address _____ City _____ State ___ Zip _____

Cell Phone _____ Home Phone _____ Email_____

PAYMENT IS EXPECTED AT THE FIRST SESSION OR PROVIDE EAP AUTHORIZATION NUMBER and OR INSURANCE INFORMATION

INSURANCE INFORMATION (PRIMARY)

Name of Insurance Company _____ Phone Number _____

Co-pay Amount:_____ Deductible: _____ID Number _____ Group Number _____

Subscribers Name _____DOB: _____ City _____ State _____ Zip _____

EAP information: Name:_____ Authorization Number: _____

TRUSSVILLE FAMLY COUNSELING

THERAPIST-CLIENT SERVICES AGREEMENT

- I understand that I or my responsible party is responsible for my bill, not my insurance company. If my insurance does not pay in a timely fashion, I will pay the bill in full.
- I, the undersigned, hereby agree to pay all amounts and charges for services rendered by Trussville Family Counseling no later than thirty (30) days of the rendering of said services unless other specific written arrangements are made.
- I also understand that unless a cancellation of appointment is made twenty-four (24) hours in advance of said appointment, that I will be subject to a charge for the time reserved.
- I agree to receive telephone/email messages to confirm appointments.
- I authorize the release of any medical information to my insurance company that is necessary to process my claims and request payment to Trussville Family Counseling (TFC).
- I understand that Trussville Family Counseling is a group of independent mental health professionals, who share certain expenses and administrative functions. While the members share a name and office space, each practitioner is completely independent in providing clinical services, and is fully responsible for those services. Professional records are separately maintained and no member of the group has access to them without my specific, written permission.

Signature _____ **Date** _____

Patient or Responsible Party

ACKNOWLEDGEMENT OF RECEIPT OR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of my Notice of Privacy Practices from Trussville Family Counseling (Tear off & keep page 3)

Signature _____ **Date** _____

Patient/Personal Representative

Printed Name of Patient/Personal Representative _____

If Personal Representative, relationship to patient _____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ _____ **Individual refused to sign**

☐ _____ **Communication barriers prohibited the acknowledgment**

☐ _____ **An emergency prevented us from obtaining acknowledgement**

(Patient Copy)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MUCH MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy information, that may identify you and that relates to your past, present or future physical or mental health or condition and related care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in effect. We reserve the right to make changes to the terms of our Notice and to make such new Notice provisions effective as to all your protected health information ("PHI") We will post each revised Notice in our office, make copies of the revised Notice available up request and post the revised Notice on our website.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

Treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider... For example, we may share PHI with other health care providers involved in your treatment, such as [sending a copy of your medical records to a specialist to whom you are referred] or [sending certain PHI to a laboratory that is conducting your tests] or [with a pharmacy when calling in your prescription].

Payment. We may use or disclose our PHI to obtain payment or be reimbursed for the health care and related services we provide you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

Health Care Operations. We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs licensing requirements, or conducting a medical review or audit.

Incidental Use or Disclosure. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

You Can Object to Certain Uses or Disclosures. For each of the uses or disclosures of your PHI listed below, if you are present and able, we will either (1) obtain oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgement, that you do not object. If you are unable to object, we will use our professional judgement to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- To a relative, friend or other person identified by you, only by your PHI, that is directly relevant to that person's in your health care or payment for health care.
- To a family member, personal representative, or other person responsible for your care, only on your PHI, necessary to notify such individuals of your location, general condition to death.
- To a private or public agency for disaster relief purposes (even if you object, we are still permitted to share your PHI as necessary for emergency circumstances).

Required Uses or Disclosures. We are required by law to disclose your PHI to you, pursuant to your patient right of access and accounting as described below. We are also requires to disclose your PHI to the Secretary of Department of Health and Human Services, when required, for their investigation of our compliance with privacy laws.

Our Contact With You. We may use or disclose your PHI to provide you with appointment reminders (such as sending postcards or leaving a voicemail message, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.

Business Associates. WE may use and disclose your PHI with our business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf, pursuant to a written agreement that contains terms regarding protection of your PHI.

Trussville Family Counseling

Court Policy

During the course of the counseling process, it may be necessary to request documented information from your therapist for attorneys, human resource managers, corrections officers, courts etc. Our practice guidelines are to provide a notarized affidavit within 2 weeks of the request, for a cost of $175-$325 to the client, due upon receipt of said affidavit. Affidavits are legal documents used in court in the therapist's stead. All clients agree to waive the right to subpoena any therapist associated with Trussville Family Counseling. In the event the therapist agrees to be subpoenaed to court, the client agrees to pay $175 for each hour the therapist is out of the office, with a minimum of 4 hours to be repaid prior to the date of court. Payment is the responsibility of the client, as insurance companies do not cover court costs or loss of income for the therapist being out of the office. Court appearances will be at the discretion of the therapist.

I have read and understand the court policy of Trussville Family Counseling:

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

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Client Email/Texting Informed Consent Form

1. **Risk of using email/texting**

The transmission of client information by email and/or texting has a number of risks that that clients should consider prior to the use of email and or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Email and texts can be used as evidence in court.
g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of email and texts.**

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for the urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any Particular period of time.
b. Email and tests should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. A. email will usually printed and file into the client's medical record. Texts may be printed and filed as well.

d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's//legal guardian's written consent, except as authorized by law.
e. Clients'/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's /parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client Name: _____ _____

Client signature: _____ Date: _____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____

Provider Name: _____

Provider signature: _____