Fox Clinical Services

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Foxclinicalservices.com

Fox Clinical Services, LLC
New Client Paperwork

Patient Name: ____ Date of Birth: _____________

Social Security Number (for billing purposes): _______________________________________

Member or Parent Name: _______________________________ Phone Number: ____________

Address: ____

Email Address: ____

Insurance Carrier: ____

Policy Holder: ______________________________________ Date of Birth: ______________

Policy Holder's Social Security Number (for billing purposes): __________________________

Member ID: __________________________________ Group Number: ___________________

Drivers License #: ____

Policy Holder's Address and Phone if different from client's contact information:

____

____

Client's current medication list: ____

____

Referral Source:____

Welcome

Welcome to Fox Clinical Services, LLC. This document contains important information about our professional services and business policies.

Fox Clinical Services, LLC. will provide services to individuals regardless of race, color, creed, handicap, socioeconomic status and/or sexual orientation.

Client Policies and General Information

Contacting Your Clinician -

In the event of an emergency, please call 911 or go to your local emergency room. For non-emergency needs, you may leave a message for your clinician at his or her extension or if necessary, you may contact our 24-hour answering service. Please note that your clinician will not usually accept phone calls while with a client.

Confidentiality -

Fox Clinical Services, LLC. complies with those standards set forth by HIPAA. The information you provide your clinician will be treated as strictly confidential. What you tell us, stays with us. However there are exceptions, including those situations which we are required by law to report such as, suspected abuse to an individual (child and/or adult); harm or threat to self or others. While these situations are rare, you should be aware of the possible occurrence as well as the protective actions required by your clinician. These actions may include, notifying the potential victim, notifying the police, seeking appropriate hospitalization for the client, and/or contacting family members or others who can help provide protection.

Your clinician may occasionally find it helpful to consult about a case with another professional (consultant). In these consultations, he/she will make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. Unless you object, your clinician will not tell you about these consultations.

Financial Policy

Acceptance of Insurance and Client Responsibility ~

Fox Clinical Services, LLC. will bill your insurance for those services rendered at our office as a courtesy. The client/ guardian is ultimately responsible for any

outstanding balance for services not covered by insurance. The filing of insurance claims does not relieve the client of financial responsibility. In the event that a claim is rejected/ denied, it is the responsibility of the client to resolve the matter. Coverage issues or lack thereof can only be addressed by your insurance company. If your insurance or coverage changes, you are responsible for informing our office of this amendment. *Please note: billing processes may include written and/or verbal correspondence to the address(es) and/or phone numbers as well as any email listed on the Confidential Client Information Form. If this information is not acceptable for this type of communication, please discuss your concern with your clinician.

Authorization for Services (if applicable) -

Some insurance companies will often require advance authorization before they will provide reimbursement for mental health services. It is your responsibility to make sure you are taking the proper steps to obtain reimbursement from your insurer; this includes keeping track of your authorized visits. If your insurance company limits the number of sessions you are allowed per calendar year/contract year/lifetime or limits the dollar amount paid out, you are expected to maintain documentation, as it is your responsibility if you exceed this number. Fox Clinical Services is not responsible for unauthorized visits.

Collections -

If a client's account has gone unpaid for 90 days, Fox Clinical Services, LLC. reserves the right to refer the account to collections and is not obligated to inform the client. This contract serves as information provided to the client.

Court Cases -

Fox Clinical Services, LLC. will occasionally become involved in custody, visitation, or legal disputes. Should this occur, Fox Clinical Services charges a fee of $195 per hour of the clinicians time. This fee is not generally reimbursed by insurance and therefore becomes the responsibility of the client.

Credit Card Authorization -

Fox Clinical Services, LLC. reserves the right to charge the client's designated credit card for co-pays, coinsurance, and/or deductibles at the time services are rendered. Accounts not paid within 90 days of the statement date are charged the full amount due.

Divorce Situations & Payment -

We look to the adult who initiated treatment on behalf of the child to assume responsibility for payment, regardless of divorce decree documentation. As well as we may ask for you to provide a copy of the divorce decree. We expect the parents to work out payment arrangements between themselves.

Fees and Payment Expectations -

Fees for psychotherapy or testing are expected to be paid at the time services are rendered. Our office sends statements upon request. We accept cash, check and credit cards. There is a $25.00 service charge for personal checks returned for any reason. You are expected to provide payment based on the estimated payment information we received from your insurance company. This information is only an estimation of benefits, the insurance company makes the final determination on a submitted claim, and therefore this information is subject to change. Insurance company quoted benefits are not a guarantee of payment. Any payment arrangements, other than payment in full must be approved in order to keep your account from being considered past due.

Insurance -

It is in your best interest to verify the details of your health insurance policy and share that information with Fox Clinical Services, LLC. Fox Clinical Service's Business Office will assist you in verifying your coverage and submit your claims to the insurance company. However, you remain responsible for knowing your insurance benefits. You also remain personally responsible for deductibles, co-payments, coinsurance, non-covered, ineligible, or unauthorized services. We recommend that you verify your coverage prior to or within 24 hours of the first appointment to be sure that your clinician is a covered provider and these services will be covered.

Missed and Late Cancelled Appointments -

Missed appointment or appointments cancelled less than 24-hours will be charged a $50.00 no show / late cancel fee by Fox Clinical Services, LLC. Missed appointments are not a billable service to insurance companies. These appointments are billed to the designated credit card given by the client. Furthermore, no show or late cancel testing appointments will be billed a $50.00 fee for each of the scheduled testing hours.

__________________(initials)

Statements of Understanding

I acknowledge that I have received, have read (or have had read to me), and understand the Client and Financial Policies. I further acknowledge that I have had the opportunity to ask questions about the agreement with my clinician. ____________ (initials)

I do hereby seek and consent to take part in the treatment by the clinician named below. If enrolled in therapy, I understand that developing a treatment plan with this clinician and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to take an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinician. ____________ (initials)

I am aware that I may stop my treatment at any time and that I am still responsible for paying for services already rendered. I understand that the financial, including insurance aspect of the counseling process is my complete responsibility. ____________ (initials)

I understand that I must call to cancel an appointment at least 24 hours before the time of my appointment or full payment is expected. I understand that Fox Clinical Services has the right to charge my designated credit card. ____________ (initials)

I understand that if I do not pay my bill within 90 days of the statement date or make financial arrangements, Fox Clinical Services, LLC. has the right to charge my designated charge card the full amount. I further understand that if I have not made a payment on my account within 90 days, Fox Clinical Services, LLC. has the right to turn my account over to collections without my advance notice. ____________ (initials)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive is not made, the clinician may stop treatment. ____________ (initials)

I understand and agree that Fox Clinical Services, LLC. and it's billing consultant may provide to me, by electronic means, information regarding my account services. Communication may include your name and other information regarding billing and payments, making or scheduling appointments, and updating demographics. I acknowledge that by giving my consent I demonstrate that I can access the information that Fox Clinical Services, LLC. provides to me electronically. I understand that by choosing to communicate with Fox Clinical Services, LLC. electronically that I assume all risks associated with this chosen method of communication. I may also withdraw my consent in writing at any time. ____________(initials)

Client Signature: _________________________________ **Date:** ___________

(12 years of age or older)

Parent/Guardian Signature:________________________ **Date:** ___________

Second Client Signature: __________________________**Date:** ___________

(If couples)

I, the clinician, have discussed the information above with the client (and/or with his/her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Clinician Signature: __________________________**Date:** ________________

Credit Card Authorization Form

Fox Clinical Services, LLC requires that all patients have a credit card on file. This conveniently assists in the collection of patient responsibilities at the time of service and minimizes the need for other billing. Account numbers are kept secure. At any given visit you may choose to pay by cash, or check, or defer to the credit card on file. You may also revoke this agreement in writing at any time. Your cooperation is much appreciated.

Credit Card Information: Please be sure to complete all sections.

1) Card Holders Name: ____

2) Credit Card Number: ____

3) Expiration Date: ____

4) 3 Digit Security Code on back of card (4 digits on front of AmEx): _____________

5) Billing Zip Code of Credit Card: _______________________________________

4) Type of Card: Visa, MasterCard, AmEx, Discover, Flex spending

5) Card Holders' Signature: ______________________________Date: __________

6) Card Holder Phone number: ________________________________

_____________(initial) I understand that by signing above, I am authorizing Fox Clinical Services, LLC. to charge my credit card for balances 90 days past due. These balances may include unpaid co-pays, co-insurance amounts, deductibles, and/or charges for missed/late cancelled appointments. I understand that Fox Clinical Services, LLC. can provide me a statement as well as a receipt for any charges that are applied to the credit card upon request. Fox Clinical Services, LLC. will contact me if my card is declined or expired should I fail to update this information.

____

Client Signature (12 and over) Date

____

Guardian Signature (if applicable)   Date

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.

If you have any questions about this notice please contact Nick Costakis.
Fox Clinical Services, LLC. is committed to protecting and preserving your privacy. We understand that health information about you is personal and that you are concerned over how it is used.

This **Notice** of Privacy Practices describes:
How the healthcare professionals ,staff, employees and associates may use and disclose your protected health information to carry out treatment, payment and health care operations and for other purposes that are permitted or required by law: and Your rights to access and control your protected health information.

"Protected health information" is information about you that relates to your past, present or future physical or mental health or condition and related health care services, and that includes demographic information that may identify you. **The terms of this Notice apply to all records containing your protected health information that are created or retained by our practice.**

We are required by federal law to maintain the privacy of your protected health information, as described in this notice. We are also required to provide you with and abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice of Privacy Practices at any time, and the new Notice of Privacy Practices will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. We will at all times keep a copy of the most current version of this Notice posted in a visible location in our office.

1. HOW YOUR PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED

A. Permitted Uses and Disclosures of Protected Health Information

Once you have been provided with this Notice, and you have had the chance to acknowledge that you have received it, we may use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your clinician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the clinician's

practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Please note: The information you share in your therapy or testing session with your clinician will not be disclosed to individuals outside our professional staff without your knowledge and written authorization, in accordance to the laws governing mental health practices. Any exceptions to this are noted in Section C.

Treatment: We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may also disclose protected health information, with your written permission, to other clinicians that may be treating you. For example, your protected health information may be provided to a clinician to whom you have been referred to ensure that the clinician has the necessary information to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for your therapy or testing may require that your relevant protected health information be disclosed to the health plan to obtain authorization for services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support our business activities. Examples of these activities include, but are not limited to: quality assessment activities, case management, and calling you by name in the waiting room when your clinician is ready to see you. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, collection services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may also send you information about our services and practice.

Appointment Reminders: We may use and disclose your protected health information, as necessary, in contacting and reminding you of your upcoming appointment(s).

Treatment Options: We may use your PHI to inform you of potential treatment options or alternatives. Health or related Benefits and Services: We may use your protected health information to inform you of other services or benefits offered by our practice or an affiliated organization that may be of interest to you.

B. **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing except to the extent that your clinician or Fox Clinical Services, LLC. has taken an action in reliance on the use or disclosure indicated in the authorization.

C. Uses and Disclosures of Protected Health Information That May Be Made Without Your Consent, Authorization or Opportunity to Object.

We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. **Mental health codes will supercede these codes when more stringent and durable.** You will be notified, as required by law, of any such uses of disclosures.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your clinician shall try to provide you with this Notice as soon as reasonably practicable after the delivery of treatment. If your clinician or business associate is required by law to treat you and the clinician has attempted to provide you with this Notice but is unable to do so, he or she may still use or disclose your protected health information to treat you.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition we may disclose your protected health information if required by law and if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (**3)** pertaining to victims of a crime**,** (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your clinician and Fox Clinical Services, LLC. uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Our Practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Please contact our Privacy Official if you have questions about access to your medical records. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

You may have the right to have your clinician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Official to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. The right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations. You have the right to receive specific

information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if they pay out-of pocket in full for the healthcare service. You have the right to be notified if there is breach of your unsecured PHI.
You must sign an authorization before PHI can be released for any use and disclosure not described in the Privacy Notice.

Signature of Client: ________________________________ Date: ________________

Signature of Clinician: _____________________________ Date: _________________

Consent to Release Information

I authorize Fox Clinical Services, LLC or my clinician, ________________________________,
to **release and/or exchange the following information regarding** (client name)

__________________________________:

____

____

____

____

(State specific nature of information to be disclosed.)

This information should only be released to and/or exchanged with:

Name: ____

Phone: __________________________________ Fax: ____________________________

Address: ____

Email: ____

This authorization shall remain in effect until: __________________ (month/day/year).
If no calendar date is stated, information may be released only on the day the authorization form is received by the clinician.

You have the right to revoke this authorization, in writing, at anytime. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

____ __________________

Client Signature (12 years or older) Date

____ __________________

Signature of Parent/Guardian Date

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

____ __________________

Witness Signature Date

VIRTUAL VISIT INFORMED CONSENT

Welcome to the Fox Clinical Services. This statement of understanding has been prepared to help explain policies and procedures related to electronic services or virtual visits provided by mental health specialists.
As a client receiving mental health services through telehealth methods, you understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. If a need for direct, face to face services arises, it is your responsibility to contact providers in your area or to contact this office for a face to face appointment. You understand that an opening may not be immediately available.
3. You may decline any telehealth services at any time without jeopardizing your access to future care, services, and benefits.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. While specific encryption measures have been taken by Fox Clinical Services to protect the information that will be communicated between you and your provider, the privacy and confidentiality of computer mediated communication cannot be 100% guaranteed. Your provider will take every measure to safeguard your information, but you should be aware that there is a very small chance the information may be stolen from transmission between yourself and the provider.
5. Also, if you decide to save the information discussed in your virtual online visit to your computer as a transcript, you are encouraged to take steps to ensure this information remains confidential. Possible breaches to your privacy could occur if another individual(s) has access to your computer.
6. Additionally, mental health specialists have a duty to warn if there is an indication that the patient is a danger to themselves or others.
7. Virtual visits provide many conveniences and advantages for patients. However, not all issues or problems are clinically appropriate for online services. Your provider may recommend the provision of face-to-face services for specific issues. The provider and the patient will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
8. Any family member or other individual that you would like to have present during the virtual visit must also sign this document. To ensure patient safety and privacy, you will your best to participate in the virtual visit from a private location. All individuals present for the virtual visit must be within view of the camera so the provider is aware of who is participating.
9. Virtual visits should not be used for emergency medical or mental health needs. In emergency situations go to the nearest emergency room, or call 911.
10. It is your responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

11. The laws and professional standards that apply to in-person mental health services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Client Signature:____Date:________________
(12 years of age or older)

Parent/Guardian Signature:________________________________Date:________________

Clinician Signature:_______________________________________Date:________________