2803 Boilermaker Court, Suite 1C
219-286-7043 (O) 219-246-4655 (F)
Valparaiso, IN 46383

Date_____ **DX Code**_____

Therapist_____

Patient Information

Patient Name (Print) _____ **Date of Birth** _____
Last Name First Name Initial

Street Address_____ Home Phone _____

City_____State_____ZIP_____ Work Phone _____

Soc. Sec. #_____Emergency Contact_____ Emerg Phone _____

Sex: Female Male Other Age_____ Marital Status: Single Married Partnered Divorced Separated Widowed Other

Employer/School _____ Occupation_____

Text Reminders: ____YES ___ NO **Voicemail:** ____YES___NO **Cell Phone** (_____)_____

Referred By:_____

Primary Insurance

Primary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID #_____ Group/Plan #:_____Effective Date:_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
Last name First Name Initial

Address_____City_____State_____Zip_____

Date of Birth_____ Soc. Sec#_____Employer_____

Secondary Insurance

Secondary Insurance Company_____ Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID #_____Group/Plan #_____Effective Date:_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship_____
Last name First Name Initial

Address_____City_____State_____Zip_____

Date of Birth_____ Soc. Sec#_____Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if patient is a minor?)

Name _____Relationship _____

Address_____Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship to Patient Date

Aspire Counseling Services

PAYMENT POLICY AGREEMENT

1 Payment is preferred at the time of service or due upon receipt of your statement. If unable to pay at that time, arrangements for payment should be made with *Aspire Counseling Services LLC.*
2 I understand that all charges are my responsibility to pay. If I carry insurance, I realize that insurance payments do not always cover all fees and that I am responsible for any part not covered.
3 **I understand that appointments not cancelled within 24 hours are subject to a $50 fee.**
4 I understand that some services such as court appearances, school meetings and documentation requests may be subject to fees not covered by insurance or other third party payers. In these cases payment becomes the responsibility of the client.
5 I agree to pay any unpaid balance due and owing on my account within sixty (60) days from the date such services are rendered.
6 I agree that if any portion of my account remains unpaid after the passage of ninety (90) days, it shall be considered delinquent for the purposes of collection.
7 If and in the event that any portion of my account becomes delinquent (as defined by paragraph 5) and it becomes necessary to institute legal proceedings to collect payment, I further agree to pay the attorney fees incurred through litigation and/or other efforts undertaken to collect such delinquent sums.

I hereby authorize payment of medical benefits to Aspire Counseling Services, LLC. and also authorize the release of any medical information needed by the insurance company in order to provide payment on this account.

I have read the above statement and hereby agree to same.

Signature Responsible Party/ Client **Date**

Printed Name of Responsible Party **Relationship to Client**

CONSENT TO TREATMENT

-I do hereby seek and consent to take part in the treatment by the assigned therapist. I understand that developing a treatment plan with this therapist and regularly reviewing our work towards 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 therapist.
-I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have received.
-I **know that I must call to cancel an appointment at least 24 hours before the time of the appointment**. If I do not cancel or show for appointment, I will be charged.

My signature below shows that I understand and agree with all of these statements.

Signature of Client **Printed Name** **Date**

Signature of Parent/Guardian **Printed Name** **Relationship to Client** **Date**

I, the therapist, have discussed the issues above with the client (and/or his or 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.

Signature of Therapist **Printed Name** **Date**

_____ Copy accepted by Client **Initial Yes or No** _____ Copy kept by Therapist **Initial: Yes or No**

Aspire Counseling Services

NOTICE OF PRIVACY PRACTICES

This NOTICE of Privacy Practices contains important information about your right to privacy, confidentiality and access to your medical records. A federal law, the Health Insurance Portability and Accountability Act (HIPPA), requires you be informed about use and disclosure of your Protected Health Information. This is the required Notice of Privacy Practices. Law requires us to obtain your signature, acknowledging receipt of these practices. Your signature then represents an agreement with you. You may revoke it at any time, by re-signing and dating it. Or you may send a signed written revocation to our office. The revocation is binding unless there are obligations imposed on the office by your health insurer, to process claims, satisfy financial obligations or comply with certain laws relating to disclosure.

The HIPPA Act requires this office to:

1. Keep your medical information private, except as noted below.
2. Give you this notice describing our obligations, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1 Change privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. Changes in new terms may be effective for all medical information kept, including information previously created or received before the changes.

2 Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Health Information: We are permitted to use and disclose medical information as listed below. We will seek your oral or written consent in most cases to disclose your health information.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to health and emergency medical professionals who need to be informed because they are treating or taking care of you. We may also share medical information about you with your regular health care professionals when you have consented.

FOR PAYMENT: We may use and disclose certain pieces of information about your care to a third-party payer, such as an insurance company. Payors may need to know for instance, your diagnosis, and dates you have been seen for therapy. In addition, a collection service or attorney may need information to pursue payment due.

FOR HEALTH CARE OPERATIONS: Our office may use your medical information within the office, to provide care, operate with fiscal responsibility, create records, measure improvement, engage in treatment planning, continuing training and education, and licensing other third party requirements.

LIMITS TO CONFIDENTIALITY: The law protects the privacy of communications between a patient and a psychotherapist/psychologist. In most situations, only information you have consented to release about your treatment will be shared. You will give your written consent (and sometimes in an emergency, oral consent). However, there are exceptions to this privacy protection.

***Consultation*:** On occasion, psychotherapists/psychologists consult with other health and mental health professionals about client care. This allows for ongoing improvement of case care, remaining current on "best practices," ongoing training and education, and continuity of care.
Also, the associates at *Aspire Counseling Services* may collaborate within the practice to improve quality of services provided. Other professionals are required to hold this information in confidence.

***Office staff*:** Within the office, you may interact with other clinical staff and office staff. They may have some information about you due to scheduling, billing, accepting payments, and maintaining records. Staff members have been given training about protecting your privacy. They are not allowed to share information that you are a patient of this office. You may be seen by other patients in the waiting room. We ask you to respect their privacy and refrain from disclosing their presence in our office.

Court Orders, Judicial, and Administrative Proceedings: We are required to provide information if ordered by the Court, or in connection with specific court ordered treatment. You will be made aware of these requests if currently in treatment.

***Danger to Self or Others*:** If you pose a danger to yourself or others, we may need to disclose information to an intended victim and/or to police authorities to safeguard you and others. If you are a danger to yourself, hospitalization will be recommended.

***Victims of Abuse, Neglect, or Domestic Violence**:* We are mandated to disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

Workers Compensation: We may disclose treatment history, including compliance with treatment.

***Appointment Reminders and Billing**:* We may use and disclose information for purposes of sending appointment reminders and billing statements.

***Financial Privacy*:** We have the right to deposit checks you provide in payment for services, as well as third party reimbursements, that may bear your name, and therefore identify you as a recipient of services at this office.

MINORS AND PARENTS: Patients under the age of 18, not yet emancipated, should be aware that parents have the right to examine medical records or discuss therapy progress. It is left to the discretion of the psychotherapist/psychologist to determine how much or little is disclosed to parents. Behaviors which exhibit current or potential harm to self or others are likely to be shared with parents. It is essential that children and especially teenage patients feel that they are provided confidentiality, or it may hinder disclosure and treatment. However, family therapy is usually used to bring essential information to light. Custodial parents must provide documentation regarding which parent has medical authority for a minor.

***Other Situations*:** The above list is not exhaustive, so there may be other instances in which health information is disclosed.

MEDICAL RECORDS: Laws and standards of practice require medical records be kept. Your clinical record, containing psychotherapy notes, test results, and assessments are kept separate from your billing records. Clinical records vary per patient, depending on the nature of the treatment and progress. You have the right to examine your records, upon written request. You have the right to have records, diagnosis, interpretation and test results explained to you. With a written request you may have your records sent to other professionals - such as a new therapist, a school counselor or an attorney. Be aware that if you are in conjoint therapy with a spouse or significant other, the identified patient has the right to the record. Written consent from the identified patient is necessary to release it to another party. If records are to be copied, there may be a fee per page and a three-day wait for those records to be copied. Please be aware that if amounts are owed on your account, records will not be made available until payment for services has been received. Electronic Medical Records will be maintained by third party venders as chosen by Aspire Counseling Services.

Insurance Carriers, HMOs and EAPs often require a diagnosis and assessment of the problem before providing authorization to treat. If your Carrier, HMO, or EAP, requires pre-authorization, you are responsible for obtaining an initial authorization. Information on progress being made in therapy and issues being addressed may have to be released to obtain continued reimbursement of services.

NOTICE OF PRIVACY PRACTICES

If you have any questions about this notice or if you think that your privacy rights have been violated, please speak to your therapist directly. You may also put your concerns in writing and I will respond to you. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may keep a copy of this notice.

Your signature on this page indicates you have read and understand the privacy policies of this office.
You have received a copy of the notice, in compliance with HIPPA.

Signature of Client	Printed Name	Date

Signature of Parent/Guardian/Representative	Printed Name	Relationship to Client	Date

☐ **Responsible Party/Client refused to sign**