Prosperity Counseling
1580 Chapel Street
New Haven, CT. 06511
(203) 717-9900

CLIENT INFORMATION

Date:_____ Referral Source:_____

Client Name: _____ Date of Birth: _____ Age: _____

Marital Status:_____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address:_____ Preferred Contact source:_____

Employer:_____

Emergency Contact : _____Phone:_____Relaltionship_____

Personal Physician & Phone _____ _____

Prescribing Psychiatrist & Phone :_____

HEALTH INSURANCE CARRIER: Name of Insurance Plan or Program: _____

Policy Number: _____ Group Number: _____

Policyholder (self, spouse, parent, etc.): _____DOB:_____

Policyholder's Address:_____

Additional health insurance _____

Deductible:_____ Copay:_____

PRESENTING PROBLEM:

_____

Prescribed Medications:

_____

Signature _____ **Date:**_____

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Consent to Treatment and Agreement

Dear Client ("You"),

As the practitioners and staff (the "Staff") of **Prosperity Counseling,** we would like to extend our appreciation for the opportunity to work with you and your family. We look forward to an ongoing therapeutic relationship with you now and in the future. In order to facilitate our mutual cooperation and understanding, we would like to advise you as to your right to consent to treatment and highlight our administrative and financial policies for your review and agreement.

Prosperity Counseling provides therapeutic assessments, counseling, and psychotherapy services for individuals, children, couples, families, and corporate clients using a variety of methods and client-specific treatment options. At the outset of our working relationship, you have the right to consent, or to refuse to consent, to receive diagnostic evaluation, examination, counseling, and treatment from our Staff; your consent is deemed to be given and effective by your signature at the end of this form, and such consent shall remain effective until and unless revoked in writing at a later date. Note that express authorization through your signature of an additional, distinct form (titled "Authorization to Release Information") is required in order for our Staff or office to disclose or exchange records pertaining to your mental and/or medical health, psychiatric and/or psychological evaluation and/or treatment, HIV/AIDS diagnosis and/or treatment, and drug and/or alcohol abuse.

Please be advised of the following policies of **Prosperity Counseling:**

- We expect that you will render payment for services at the time that such services are provided unless you have made special arrangements with our office in advance.
- If you elect to make Out-of-Pocket payments, you agree to pay at the rate of $_____ per session. Out-of-Pocket fees are due at the time of visit and will not be billed to insurance.
- You are responsible for understanding your insurance benefits. Our office will verify your benefits upon your request however the information we provide to you is not guaranteed accurate. You are responsible for providing our office with advance notice of any changes to your insurance.
- Claims for any sessions denied by an insurance company due to your negligence will be billed/charged in full to you.
- **You are responsible for setting and keeping scheduled appointments. Missed sessions or sessions not cancelled more than 24 hours prior to the appointment will be billed at $60.00 per session and are not billable to insurance.**
- If you miss three of your scheduled appointments and/or we do not meet or speak to you within 30 days after your most recent appointment, your file may be closed. Thereafter, you must complete a new intake in order to continue to receive treatment or any services from our Staff.
- All out-of-session services provided are not billable to insurance and will be billed at $100 per hour based on the amount of time devoted thereto by any clinician. These services may include: responding to emails, speaking with other providers, and phone calls/text messages with you and/or your family members outside of a 10-minute time frame.
- Any written report generated by our office for another provider is billed at $100 per hour.
- A therapist's presence at court is billed at $150 per hour (including travel time).
- A therapist's presence at a school-based meeting is billed at $100 per hour (including travel time).

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You hereby agree to allow Karen Tyson, LADC DBA Prosperity Counseling to bill you for any of the above services if not paid in full at the time of visit.

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You hereby authorize Karen Tyson, LADC DBA Prosperity Counseling o file any claims for payment of any portion of bills for treatment as may be necessary and assign all rights and benefits to Karen Tyson LADC therefore. You further agree, subject to state and federal law, to pay all costs, attorney fees, expenses and interest in the event that Prosperity Counseling takes action to collect payment for services because of your failure to pay all incurred charges in full.

You understand that it is impossible to guarantee the security and confidentiality of information stored on computers or telecommunications equipment connected to the internet. You further understand that it is impossible to guarantee the confidentiality of information being transmitted via email, text, cordless telephones, mobile telephones, or similar telecommunications equipment. You hereby agree to waive legal action against Tides of Mind Counseling and its Staff with regard to the storage or transmission of any confidential information and further hold Prosperity Counseling and all of its Staff harmless for any interception of your medical information resulting from use of the aforementioned equipment. Please be advised that **Prosperity Counseling** may rely on a third-party billing company for claims processing and billing, pursuant to a HIPAA- compliant Business Associate Agreement.

By signing this form, you agree that you have read, understand and hereby agree to the above policies and accept responsibility for your account. Further, you consent to treatment by Prosperity Counseling for yourself and/or your minor child (name & DOB) _____, including diagnostic evaluation, examination, counseling and therapy, and you confirm that you have the legal right to consent to your child's mental health treatment without the consent of any other individuals. As stated above, this consent shall remain effective until and unless revoked in writing at a later date.

Client /Responsible Party Date

Therapist Date

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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.

As a Mental Health Provider, **Prosperity Counseling** and its practitioners and staff (the "Staff") are required by federal law to take reasonable efforts to maintain the privacy of your medical information. In the course of evaluation and treatment, we may receive and maintain medical information from other medical providers ("Providers") from whom you have received services; this medical information is known as Protected Health Information, or PHI. In accordance with the law and for your benefit, we will at all times take reasonable steps to secure client records, adopt clear privacy procedures, and restrict other parties' access to your PHI – while ensuring that you can obtain copies of your records and expressly authorize transfer of your records to other Providers, as may be necessary. We will not disclose your PHI without your permission, except as described in this notice. We encourage you to ask any questions you may have regarding this notice and our policies for safeguarding your PHI.

Prosperity Counseling reserves the right to revise our privacy practices and implement new policies effective and applicable on a going-forward basis to all PHI maintained by our office and Staff. Should we implement such a change to our privacy practices, we will amend this notice, post notice of such changes in our office, and provide clarification regarding such changes upon request. This notice is effective and current as of March 7, 2017.

USES AND DISCLOSURES:

We believe that protecting client confidentiality and responsibly maintaining your individually identifiable health information and PHI are of the utmost importance. As a result, we have adopted clear internal privacy procedures and have trained our Staff to understand and abide by our practices; we strive to secure and protect our electronic and physical records, our electronic or telephonic communications with you, and confidential information and materials related to your treatment and your relationship with our Staff. Pursuant to HIPAA rule 45 CFR 164.501, we afford special protection to psychotherapy notes, such notes being defined as documentation by a mental health professional analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session, and such notes being separate from the rest of your medical record. We will not provide these sensitive notes to third-party payers without your express authorization.

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It is our policy to obtain your written authorization through the use of an "Authorization to Release Information" form prior to disclosing your PHI to any person or entity outside of our office for any purpose other than treatment, payment and in-office health care operations (as described in more detail below). As noted in the form, you may revoke your authorization at any time, except to the extent that we have already acted upon it. Such authorization automatically expires after a period of one (1) year.

We may use your Protected Health Information (PHI) without authorization for:

- Treatment, e.g., to share information with other Providers involved in your care;
- Payment, e.g., to a third-party billing company, pursuant to a HIPAA-compliant Business Associate Agreement, or to the State Department of Administrative Services to bill for your healthcare services;
- Healthcare operations, e.g., to internal staff for evaluation of the quality of services provided; and/or
- Reminding you of appointments with **Prosperity Counseling** or its Staff.

Other permitted disclosures of your Protected Health Information (PHI) without authorization might include the following:

- Disclosures required by law, e.g., to the Department of Children and Families when a law requires that we report suspected abuse or neglect;
- Public Health, e.g., mandated reporting of diseases, injury or vital statistics;
- To avert a serious threat to the health and/or safety of you and/or others;
- In response to a court order, e.g., if a judge orders that specific portions of your record be produced during a civil or criminal legal proceeding; and
- If deceased, limited information to coroners, medical examiners or funeral directors.

YOU HAVE THE RIGHT TO:

- Request restrictions on certain uses and disclosures of your PHI;
- Receive reasonable confidential communication of PHI, e.g., ask to be contacted at an address or by a means of communication of your choosing;
- Inspect and copy your medical records by written request, within a reasonable timeframe that is not disruptive to our office;
- Submit a written request to amend your medical records, which request must specify which portion of the record you wish to amend and how. Our Staff reserves the right to deny the request in its sole discretion;
- Receive an accounting of our office's disclosure of your PHI for seven (7) years prior to your request; and
- Receive a paper copy of this notice.

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HOW YOU CAN REPORT A PROBLEM:

If you have any concerns about our efforts to ensure your privacy, we encourage you to contact Karen Tyson, 1580 Chapel Street, New Haven, CT 06511. If you feel your privacy rights have been violated, you have the right to file a written complaint with the U.S. Department of Health and Human Services' Office for Civil Rights, either by visiting https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, by contacting OCRComplaint@hhs.gov, or by writing to Centralized Case Management Operations, U.S. Dept. of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201.

(Please Initial Each Item Below to Indicate Your Understanding and Agreement)

_____ I ("CLIENT") ACKNOWLEDGE THAT I HAVE RECEIVED AND READ A COPY OF THIS NOTICE AND I GIVE **Karen Tyson DBA Prosperity Counseling** THE RIGHT TO TREAT ME AND BILL MY HEALTH INSURANCE.

_____ IF COURT PRESENCE IS REQUIRED OF A THERAPIST, CLIENT IS RESPONSIBLE FOR A $150/HR CHARGE.

_____ 24 HOUR ADVANCE NOTICE IS REQUIRED TO CANCEL APPOINTMENTS, OR CLIENT IS SUBJECT TO A $60 LATE FEE.

_____ CLIENT IS RESPONSIBLE FOR GIVING ADVANCE NOTICE OF ANY CHANGE OF INSURANCE AND IS RESPONSIBLE FOR PAYMENT IF INSURANCE DENIES DUE TO INSURED'S NEGLIGENCE.

_____ A 2% LATE FEE WILL BE ASSESSED IF COPAY IS NOT PAID AT THE TIME OF SESSION, WITH A MINIMUM CHARGE OF $0.50.

_____ _____

Client/Responsible Party Date Therapist Date