THE COUNSELING PRACTICE OF BETH A. WOMBOUGH, MS, LMHC, PA

CLIENT INTAKE INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date _____ Client's Last 4 #s of SSN: _____

Client's First Name: _____ Last Name: _____
Middle Name: _____ Preferred Name: _____

Address: _____
City: _____ State: _____ Zip: _____

Telephone (Home)_____ (Work) _____ (Cell) _____
Best Place to Leave a Message: _____ . Email Address:_____
Please initial here (__) if you do **not** want to receive messages from this practice.

Is it okay to send an email reminder of your scheduled appointments? YES/NO

Birthdate ____/____/_____ Age_____ Gender F M Race _____

Person Responsible for Payment_____
Address _____ City_____ State ___ Zip _____

Signature of Person Responsible for Payment X _____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:
Name (1) _____ Relationship _____ Home_____Cell _____
Address _____ City _____ State _____ Zip

Name (2) _____ Relationship _____ Home_____Cell
Address _____ City _____ State _____Zip _____

Physician _____ Phone _____

Psychiatrist_____ Phone _____

Referral Source
How did you hear of this practice (or from whom)? _____

Relationship: _____

Insurance Information (for clients who want the practice to file out of network claims)

Primary Insurance Company Name: _____
Member ID #: _____
Group name & group number: _____
Provider services phone number: _____
Subscriber/ Member Name: _____
Subscriber/Member DOB: _____
Client's relationship to Subscriber/Member: _____

Release of Information Authorization to Third Party/Insurance Company

I (we) authorize Beth A. Wombough, MS, LMHC, PA to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of **filing the out of network insurance claim on my behalf**. I understand that I will receive payments directly from the insurance company if one is due to me. I am responsible for paying the full fee for all sessions at the time of treatment.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice. This notice will not expire otherwise. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person responsible for account: _____ Date:

Person(s) receiving services: _____ Date:

Thank you for completing this information. Please continue to the Privacy of Information Policies, Consent to Treatment and Recipient's Rights, and Financial Policy and Payment Contract for Services forms, which require your review and signature. Should you have any questions about these documents, please let me know. I look forward to working with you.

THE COUNSELING PRACTICE OF BETH A. WOMBOUGH, MS, LMHC, PA

CONSENT TO TREATMENT AND RECIPIENT'S RIGHTS

Client Name: _____ Date of Birth: _____

I, _____ , the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at The Counseling Practice of Beth A. Wombough, MS, LMHC, PA, hereby referred as the Practice. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights informational handout and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the therapist.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Practice non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Practice, and/or B) the client refuses to comply with stipulated office policies and rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the therapist or request to re-apply for services at a later date. The practice is not obligated to respond to such requests.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Practice is protected by Federal and/or State law and regulations. Generally, the Practice may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, supervision or program evaluation. To ensure good clinical practices, the therapist/practice will, at times, seek consultation from other providers licensed under FL Chapter 490, Chapter 491, Chapter 456, or similarly licensed providers outside of the State of Florida. Client identifying information will not be shared with any of these consultants. The confidentiality laws forbid these consultants to release any information shared with them to other parties. The sole purpose of consulting is to improve the quality of the services you receive.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Practice, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is the Practice's ethical practice and duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with Beth A. Wombough, MS, LMHC, PA. Signature of client and/or representative below:

_____ _____

_____ _____

THE COUNSELING PRACTICE OF BETH A. WOMBOUGH, MS, LMHC, PA

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Results of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ AND REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the American Counseling Association Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the terms of my Notice to Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in my office, sending a copy to you in the mail upon request, or providing one to you at your next appointment time.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

1. FOR TREATMENT

2. FOR PAYMENT

I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

3. FOR HEALTH CARE OPERATIONS

I may use or disclose as needed, your PHI in order to support my business activities, including but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (i.e., answering service, software company, billing and accounting service) provided I have a written contract with the business or individual that requires them to safeguard the privacy of your PHI.

4. REQUIRED BY LAW

Under the law, I must make disclosure of your PHI to you upon request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of litigating or determining my compliance with the requirements of the Privacy Rule.

5. WITHOUT AUTHORIZATION

Applicable law and ethical standards permit me to disclose information about you and your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are: - Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as mental health licensing board or health dept.)

- Required by Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

6. VERBAL PROTECTION

I may use or disclose your information to family members or other health care professionals that are directly involved in your treatment with your verbal permission. I will document in your record such verbal permission.

7. WITH AUTHORIZATION

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

RIGHT TO AMEND: If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

RIGHT TO REQUEST CONFIDENTIAL INFORMATION: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

RIGHT TO A COPY OF THIS NOTICE: You have the right to a copy of this notice.

COMPLAINTS

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at:

200 Independence Ave, SW
Washington, DC 20201
or by calling (202) 619-0257

THE COUNSELING PRACTICE OF BETH A. WOMBOUGH, MS, LMHC

13241 BARTRAM PARK BLVD, STE. 301

JACKSONVILLE, FL 32258

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name:

Date of Birth:

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the "Notice of Privacy Practices" for the counseling practice of Beth A. Wombough, MS, LMHC, PA. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Beth A. Wombough, MS, LMHC, PA at 904.268.1696x2.

_____

Signature of Client or legal representative Date

☐ Client Refuses to Acknowledge receipt

_____

THE COUNSELING PRACTICE OF BETH A. WOMBOUGH, MS, LMHC, PA
Financial Policy & Payment Contract for Services

This psychotherapy practice (hereafter referred to as the practice) is committed to providing caring and professional mental health care to all of its clients. As part of the delivery of mental health services, the practice has established a financial policy which provides payment policies and options to all consumers. The financial policy of the practice is designed to clarify the payment policies as determined by the practice owner.

This practice is not in network with any insurance company. As a service to you, the practice will bill primary insurance companies but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases, insurance companies may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, the Person Responsible for Payment of Account is responsible for payment of these services. Clients are responsible for payments in full when services are rendered, regardless of any insurance company's arbitrary determination of usual and customary rates or decision to reimburse the member or client or not.

The Person Responsible for Payment and the client (if different) must sign this form to acknowledge acceptance of the terms. The Person Responsible for Payment is financially responsible for paying fees outlined below:

Payment methods include check, cash, Visa, Master Card or money order.

Payment Contract for Services/ Federal Truth in Lending Disclosure Statement for Professional Services

Part 1: Fees for Professional Services

I (we) have been informed of the fees for services provided by Beth A. Wombough, MS, LMHC, PA, hereafter referred to as the practice. The rates are outlined below.

- Initial Consultation	$180
- Individual psychotherapy:	$150 per hour, billable in 15 minute units.
- Court-related consultation:	$ 200 per hour, including preparation/travel
-Court-related letters:	$ 200 per letter
- FMLA/Disability paperwork:	$ 100 per hour required to complete

A fee of $ **100** per clinical hour scheduled is charged for **missed appointments** or **cancellations with less than 24 hours' notice**. I understand that if I schedule **two clinical hours** and miss or cancel the appointment without 24 hours' notice, I will be charged **$200**. If within the same 6 months, I miss an appointment twice without any notice (no show,) I understand I will be discharged for non compliance and will still be required to pay the missed appointment fees.

I (we) have read, understand, and agree with the provisions of the Financial Policy and Payment Contract for Services.

Person responsible for account:_____ Date: _____

Client: _____ Date_____