

Bluegrass Family Consultants, LLC

501 Darby Creek Rd, Ste 7, Lexington, KY 40509

PLEASE FILL IN COMPLETELY:

PATIENT'S NAME:

(Last, First MI)

Guardians (if applic)

Address

Email (optional)

Telephone (Home) _____ (Work) _____

PATIENT'S BIRTHDATE ____/____/____ Age ____ Gender __F__ __M__

Name of Spouse/Guardian _____ Phone _____

IN CASE OF EMERGENCY CONTACT:

Name (1) _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Secondary Insurance _____

Phone _____

Phone _____

ID NUMBER# _____

Contract/ID# _____

Group Number# _____

Group/Acct# _____

SUBSCRIBER _____

Subscriber _____

SUBSCRIBER DOB _____

Subscriber Date of Birth _____

Client's relationship to Subscriber:

Client's relationship to Subscriber

___ Self ___ Spouse ___ Child ___ Other _____

___ Self ___ Spouse ___ Child ___ Other _____

REFERRAL SOURCE

How did you hear of our practice (or from whom)? _____

Bluegrass Family Consultants, LLC

501 Darby Creek, Suite 7, Lexington, KY 40509

Tel: (859) 227-2337

Fax: (859) 268-2472

bluegrassfamilyconsultants@gmail.com

Financial Policy

The staff at Bluegrass Family Consultants, LLC (hereafter referred to as BFC) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers 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. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by BFC until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to BFC (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or credit cards via PayPal. Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

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

Person responsible for account: _____ Date: ____/____/____

Co-responsible party: _____ Date: ____/____/____

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Privacy of Information Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

OUR LEGAL DUTIES

State and federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

USE OF INFORMATION

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic, such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

PUBLIC SAFETY

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

ABUSE

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and his or her safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH

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

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

JUDICIAL OR ADMINISTRATIVE PROCEEDINGS

Health care professionals are required to release records of clients when a court order has been placed.

MINORS/GUARDIANSHIP

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

OTHER PROVISIONS

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, the time frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail, we will follow the same guidelines.

YOUR RIGHTS

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for nonemancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is \$.10 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict what information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might refuse to change the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

COMPLAINTS

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Kentucky State Board of Examiners of Psychology. If you file a complaint, we will not retaliate in any way.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's Name (please print): _____

Signature: _____ Date: ____/____/____

Signed by: _____ client _____ guardian _____ personal representative

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Consent to Treatment/Evaluation and Recipient's Rights

Client _____

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 Bluegrass Family Consultants, LLC, hereby referred to as BFC. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that therapy may be discontinued at any time by either party. BFC 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 pamphlet 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 Recipient's Rights Advisor.

Nonvoluntarily Discharge from Treatment: A client may be terminated from BFC nonvoluntarily, if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program 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 nonvoluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by BFC is protected by federal and/or state law and regulations. Generally, BFC may not say to a person outside BFC 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, or program evaluation.

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 BFC, 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. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is BFC's 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 nonemancipated 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 the 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 Bluegrass Family Consultants, LLC.

Signature of Client/Legal Guardian

Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

Witness

Date