Emerald Coast Counseling Center, P.A.
(DBA Destin Counseling Center)

NEW CLIENT INFORMATION

Please complete this section if client is 18 years of age or older. If client is under the age of 18, the parent or guardian completes this section and then completes the next section for the child.

Name: _____ Date of Birth: _____

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

Phone #_____ Marital Status: S__M__W__Div__Sep__

Employer: _____ Work Phone: _____

Employer Address: _____City: _____St. ____Zip_____

Length of Employment: _____ Occupation: _____

Your Family Physician: _____

Current Medications:

_____

_____

Spouse's Name: _____ Birth Date: _____

Employer_____

IF CLIENT IS A CHILD UNDER THE AGE OF 18, PLEASE FILL IN THE FOLLOWING:

Name: _____ Birth Date: _____

Address: _____City: _____State:_____Zip Code_____

List other household members:

Name Age Relationship

_____

_____

_____

_____

In case of emergency whom do you wish to have contacted?

Name_____ Phone: _____

Are you currently in treatment with, or have you ever been treated by a psychiatrist, psychologist or psychotherapist? Y_____N____ Name of person providing treatment: _____

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the New Client Information form. I certify that this information is correct to the best of my knowledge and will notify you of any changes in information.

Signature: _____ Date: _____

Primary Insurance Information

Name of Insured: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone Number: _____

Policy #_____Group #_____

Secondary Insurance Information

Name of Insured: _____

Name of Secondary Insurance or Supplemental Policy: _____

Address of Secondary Insurance or Supplemental Policy: _____

Phone Number_____

Policy #:_____Group #_____

Military Insurance Information

Tricare Yes_____No_____ Standard_____ Prime_____

VA Yes_____No_____ CHAMPVA Yes_____No_____

Sponsor's Social Security Number: _____ Sponsor's Date of Birth: _____

Sponsor's Name_____

ID Issue Date: _____ Effective Date: _____Expiration Date: _____

Sponsor's Rank: _____ Branch of Service: _____ Active Duty? _____ Retired? _____

Insurance Authorization and Insurance Assignment

I hereby authorize Emerald Coast Counseling Center, P.A. (DBA Destin Counseling Center) to furnish the information required to file claims to my insurance carriers concerning my diagnosis and treatment. Furthermore, if so arranged, I hereby assign to the psychotherapist, all payments for psychotherapy services rendered to my dependents or myself. I understand that I am ultimately responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

Adopted: 09-21-2016

EMERALD COAST COUNSELING CENTER, P.A.
DBA Destin Counseling Center

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and understanding of our payment policy.

Considerations:

1. **Payment of services is due at the time services are rendered**. **Effective January 1, 2023, the fee of service for all new clients is $140 per session.** We accept cash and all major credit cards.

2. **Cancellation Policy: A cancellation fee of $140.00 will be charged to your account for appointments at which you "fail to show", and for appointments cancelled without a 24-hour advance notice. Notice can be given to our answering service after hours and on weekends.**

3. We will be happy to help you process your insurance claim form for your reimbursement. If you wish for us to file your insurance you must notify us within 90 days of the first day of treatment.

4. Your insurance company may reimburse on a "schedule of fees" for which your provider has contracted (If provider is in network). The "co-pay" amount determined by your insurance company or a predetermined cost of service, considered to be "usual, customary, and reasonable for this geographical area is assessed for services rendered.

5. Not all services are a covered benefit in all contracts. Some insurance companies select certain services that they will not cover. For example, it may be recommended during your treatment that you undergo psychological testing. Most insurance companies will not cover those fees. If this is the case, you will be responsible for those fees, which your therapist will be happy to discuss with you before the testing is done.

6. We must emphasize that as mental health providers, our relationship is with you and not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our clients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above stated information, or an uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

Signature: _____ Date: _____

Adopted: 03-21-2003

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Client Name _____

Person or Organization Granted this Consent:

_____

_____

_____

_____

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" **with your informed consent.**

With this consent form, we are asking you to make permission **explicit** for purpose of filing your insurance using the information required by your insurance company. By signing this consent, you are giving us permission to use or disclose your protected health information for this purpose.

The use and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are not permitted to file claims to your health insurance carrier if this consent is not granted, or if the consent is later revoked. You will be held responsible for payment of services not filed and covered by your insurance carrier.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____

Signature of Client or Personal Representative Date

Relationship of Personal Representative to the Client: _____

Emerald Coast Counseling Center, P.A.
(DBA Destin Counseling Center)
215 Mountain Drive, Suite 106 Destin, FL 32541 Office Phone: 850-837-9100 Fax: 850-837-3774

12273 US 98 E, Suite 204, (HOLIDAY PLAZA) Miramar Beach, FL 32550

Adopted: 03-21-2003

CONFIDENTIAL COMMUNICATIONS - ALTERNATIVE CONTACT INFORMATION

Destin Counseling Center
215 Mountain Drive, Suite 106 Destin, FL 32541 Office Phone: 850-837-9100 Fax: 850-837-3774

12273 US 98 E, Suite 204, (HOLIDAY PLAZA) Miramar Beach, FL 32550

As a courtesy to you and in order to serve you better, our staff will contact you to remind you of your appointment day and time. This form allows you to designate specifically, whether you wish to be contacted and how. If you do not wish to be contacted, please note that in the section designated "Requested Accommodations".

Effective Date _____

Patient Name _____

Requested Accommodations:

_____
_____
_____
_____

Address Where We Can Send Information:

_____
_____
_____
_____

Phone Numbers:		(Circle if okay) Okay to Call?	Okay to Leave Message?
Home:	_____	Y	Y
Work:	_____	Y	Y
Cellular:	_____	Y	Y
Other:	_____	Y	Y

Billing Arrangements:

_____
_____
_____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

Adopted: 03-21-2003

NOTICE TO OUR CLIENTS
FROM DESTIN COUNSELING CENTER
RE: “ON-CALL” SERVICES

When the office is closed, our therapists take turns being “on-call” for crisis situations that need immediate attention. Should you need these services, please do the following:

First call the office at 837-9100 and leave your name and phone number so we have a record of it.

Then hang up and call 837-7465. It will forward your call to the on-call therapist. Leave your name and number on their voice mail and they will call you right back.

The purpose of this service is to stabilize crisis situations. It is not intended to take the place of your regular therapy session. In the event your call lasts more than 15 minutes, the therapist will have the option of billing you for a session.

Please continue to use the office voice mail (837-9100) to cancel appointments or leave other messages that can be handled when the office reopens. Thanks for your cooperation!

Adopted: 03-21-2003

Emerald Coast Counseling Center, P.A.

DBA Destin Counseling Center

215 Mountain Drive, Suite 106 Destin, Florida 32541
12273 US 98 E, Suite 204, (HOLIDAY PLAZA) Miramar Beach, FL 32550
Office Phone: 850-837-9100 Fax: 850-837-3774

(Please sign at the end of page)

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.

This Notice is effective as of: April 14, 2003

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is currently in effect. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is: **Diana Sandevski**

You can contact the Privacy Officer at: **850-837-9100** and you may leave a message with office personnel that you wish to be contacted.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

With your signed consent, we may use information in your record to provide treatment to you. We may **not** disclose information in your record to help you get health care services from another provider, a hospital, etc., unless we have a signed consent from you giving permission to disclose specific health care information to the specific health care provider and for a stated reason. For example, if we want an opinion about your condition from a specialist, we may **not** disclose information to the specialist to obtain that consultation without written consent from you stating the name of the person with whom we are consulting and for what reason.

With your signed consent we may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order

to demonstrate to the insurer that the service should be covered, as long as you have signed a written consent that you wish to have your insurance carrier cover the services for which you are or will be billed.

We may **not** use or disclose information from your record to allow "health care operations", without your written consent. These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may **not** use information in your record to train our staff about your condition and its treatment without specific written consent.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations, such as filing insurance claims when you have requested that we do so. Since your records are confidential under state law, we **must** honor those restrictions. However, if, after reviewing the requirements for information to process your claims, you decline to consent, then you will be personally responsible for payment of services provided.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing to the "licensed psychotherapist" who provided services and not to the office personnel. Your request will be acted upon within thirty (30) days. If this time frame cannot be honored by your psychotherapist and an extension is necessary, you will be given the reasons for the delay in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing to the "licensed psychotherapist" who provided services. The request will be acted upon within sixty (60) days, with conditions for a delay of thirty (30) days, if necessary, which will be provided to you in writing.

You have the right to request an accounting of all disclosures made by us with your consent. This includes incidental disclosures made, in the course of correcting hardware or software problems, about account information used to bill or schedule appointments.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

We may not make any use or disclosure of information from your record unless you give your written consent. You may revoke consent in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the consent was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the consent.

Use or disclosure of your protected health information that we are required to make without your permission

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us **to report suspected child abuse or neglect.**

When there is clear and immediate probability of physical harm to you or to other individuals or to society your "licensed psychotherapist" may communicate this information only to the potential victim, appropriate family member or law enforcement or to other appropriate authorities.

When your **"licensed psychotherapist"** is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by you, health information shall be disclosed that is pertinent and required to that action.

Use or disclosure of your protected health information that we are allowed to make without your permission

When you receive mental health care, including treatment for substance abuse, information related to that care must be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We **may** disclose information from your record if ordered to do so by a judge.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may **not** disclose that information to law enforcement officials. Information of this sort that is revealed in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, may **not** be disclosed to law enforcement officials without your consent, unless it pertains to the specific conditions stated above, such as abuse of a child.

Your provider (or office staff) may contact you to provide appointment reminders as a courtesy and with your informed consent. However, you are responsible for remembering your appointment. If you do not want to be contacted or have special circumstances regarding how or where you wish to be contacted, the office personnel will provide you with the necessary paperwork to keep us informed of those conditions.

Adopted: 04-14-2003

SOCIAL MEDIA POLICY

This document outlines our office policies related to the use of social media. Please read it to understand how we conduct ourselves as Mental Health Professionals as it pertains to the Internet and other forms of electronic interaction.

Friending

We do not accept friend or contact requests from current or former clients on any Social Networking site unless there are circumstances that are discussed and agreed upon individually with your therapist and for specific reasons. That includes Facebook, LinkedIn, Instagram, etc. We believe that adding clients as friends or contacts on these sites could compromise your confidentiality and ours. It could blur the boundaries of a therapeutic relationship. If you have any questions or concerns regarding this policy, please do not hesitate to bring them up during your sessions in order to further clarify our concerns for your well-being.

Interacting

Please do not use text messaging or messaging on social networking sites to contact us unless you have spoken with your therapist and agreed to a procedure ahead of time as these sites are generally not secure and your therapist may not read them in a timely fashion. Please do not use Wall postings or other public means of engaging with your therapist as this could compromise your confidentiality. If you need to contact us between sessions, the way to do so is by phone. Direct email is a possible means of contact as long as you and your therapist have agreed upon this means ahead of time.

Business Review Sites

You may find our counseling practice on sites such as Yelp, Healthgrades, Yahoo, Bing or other places which list businesses. Some of these sites include forums which rate providers and add reviews. If you should find our business on any of these sites, please know that our listing is NOT a request for a testimonial, rating or endorsement from you as a client. It is unethical for providers of counseling service to solicit testimonials. You do have the right to express yourself on any site whether it is positive or negative but, we do urge you to take your own privacy into consideration when you are doing so. It is important to be aware that your therapist may never see these testimonials and that if you wish to make your therapist aware of your concerns or reactions, we hope that you would feel comfortable doing so directly during the therapy process. In this way, your privacy could be assured. None of this is meant to prevent or discourage you from speaking your feelings or concerns in any way including any public forum of your choosing. It is due to our concern for your welfare regarding your sharing of revealing personal information that prompts this notice.

If you believe that we have done something harmful or unethical and do not feel comfortable discussing it with your therapist, you can contact that Privacy Officer to handle any complaint. That notice is displayed in the front office.

EMAIL

Please do not use email to contact us with content related to your therapy session unless you have been assured that the email is completely secure and confidential. That can be discussed with your individual therapist regarding the level of encryption or security provided. If you do choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet Service Providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Any emails we receive from you and any responses that we send to you can become part of your legal record. Please discuss any questions or concerns that you have with your individual therapist.

Conclusion

Thank you for taking the time to review our social media policy. If you have any questions or concerns about any of these policies and procedures or regarding our potential interactions on the electronic media, please bring them to our attention so that we can discuss and resolve them.

Receipt of Notice of Social Media Policy and Privacy Practices

Version/Effective Date: ___ April 14, 2003_____

_____ _____

Signature of Client or Personal Representative Date

Relationship of Personal Representative to the Client: _____

Adopted: 11/05/2015