

Hinkle Counseling & Psychological Services, PLLC
519 E. Main Street, Ste D, Bridgeport, WV 26330
(304) 848-0660
CLIENT INTAKE FORM

GENERAL INFORMATION

Today's Date _____

Full name _____ Social Security No: _____
Address _____ Birth date ____/____/____
City _____ State _____ Zip _____ Marital Status _____
Who referred you here? (internet, doctor, etc.) _____
If a personal/professional referral, may I thank the person? Yes No

Cell phone _____ Yes No Home phone _____ Yes No
Work phone _____ Yes No Email address _____ Yes No

PRESENTING PROBLEM

Please describe the difficulties you are experiencing: _____

Please circle all of the symptoms that you have currently been experiencing:
 crying spells stomach problems impaired concentration change in sex drive
 sleep difficulties feelings of anxiety/panic change in energy level depression
 anger excessive worrying low self-esteem appetite disturbance
 Other (describe): _____
Have you ever thought of harming yourself? Yes No Someone else? Yes No

What are your goals for working together? _____

BRIEF MEDICAL HISTORY

Primary Care Physician _____
Current Medications/dosages: _____
Major Medical Problems or Hospitalizations: _____
History of Substance Abuse: Yes No Substance: _____

FAMILY/MARITAL HISTORY

Family History of Mental Health issues or Substance Abuse (person's relation to you and issue): _____
Spouse: _____ Age _____ Length of Relationship _____
Are you separated? Yes No Widowed? Yes No Divorced? Yes No
Explain: _____
Children: (indicate if step)

(name) (age) _____

Family of Origins: (birth order, family constellation, marriages or significant relationships. Include significant social/emotional/medical problems)

Have you ever been: -Physically Abused - Emotionally Abused - Sexually Abused
Current Employment _____
Highest Level of Education Obtained: _____
Arrest Record: _____
Have you Served in the Army Services Yes No When _____ Branch _____
Have you applied for disability benefits? Yes No

MENTAL HEALTH HISTORY

Have you ever received counseling? Yes No
If yes, with whom _____ Dates _____
Have you ever received inpatient mental health treatment? Yes No
Dates of hospitalization _____ Name of Hospital _____

Hinkle Counseling & Psychological Center LLC.
519D E. Main St., Bridgeport, WV 26330
CONSENT FOR TREATMENT

I, the undersigned, give consent to Hinkle Counseling & Psychological Center, LLC to evaluate or provide therapy for
_____(NAME)_____

I understand that the services received, as well as the content of our sessions, will be help to the highest standards of confidentiality by this practice. However, I have been informed and understand the following limits to confidentiality:

- The undersigned authorizes this office to release specific health information to all 3rd party payers for reimbursement, utilization review or certification. I/we also authorizes direct payment to this office from any 3rd party insurance/benefits for the services rendered. The undersigned also agrees and understands that I/we are financially responsible to this office for any changes not satisfied by this assignment.
In cases involving the treatment of minors, where applicable, a current copy of custodial agreement or guardianship shall be provided for inclusion in the chart. All parties with custodial rights must sign Consent for Treatment.
In cases of suspected abuse and/or neglect of children, persons with disabilities, or elderly, WV State law mandates that our confidentiality will be broken with a required report filed to WV DHHR Child Protective Services or WV DHHR Adult Protective Services.
Confidentiality will be broken should a circumstance arise where failure to do so could result in an imminent danger to the client or others.
In the situation of health information being requested through a court order, your therapist may be required to testify in a court proceeding.
Situations outlined in our HIPAA Privacy Notice.
Client charts are maintained for a period of 10 years form the date of last session, or in the case of a minor, for 2 years after the minor has reached his/her maturity, or 10 years from the date of last session, whichever is longer.
Should I wish a 3rd party friend or family member to accompany me during my counseling sessions, I must designate those individuals by name below:

I fully understand that the above named individuals will be privileged to my confidential information and that HCPC will not be held responsible for any kind of re-disclosure of my health information by the individuals.

I have been informed of, and consent to adhere to the following attendance policy: I agree to call at least 24 hours in advance if I am unable to keep my appointments. Should I miss two scheduled appointments without a proper excuse and/or documentation or cancel two appointments without 48 hour notice, future services will not be provided by this office. I understand that under those circumstances, should I so request,

a referral to another provider will be made.

Authorization is valid from today's date until revoked.

My signature below certifies that I understand and agree to the foregoing either on behalf of myself and/or on behalf of the client.

X _____
Signature of Client Date

X _____
Parent/Guardian Signature (if client is under 18) Date

HINKLE COUNSELING & PSYCHOLOGICAL CENTER, PLLC.

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
HINKLE COUNSELING & PSYCHOLOGICAL CENTER, PLLC.**

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
Uses and Disclosures of Protected Health Information**

Psychological Center, PLLC.'s policy does not permit the sharing of PHI. We use and disclose PHI about you for treatment, payment, and health care operations, for compliance with the Health Insurance Portability and Accountability (HIPAA) Except in limited situation, Hinkle Counseling & Administrative Simplification Rules, and in certain extenuation circumstances.

Definitions:

PHI: Protected Health Information: Your individually identifiable health information, including: diagnosis, symptoms, treatment plans, appointment times, and summaries of sessions, as well as demographic information such as name, address, phone number, among other things.

Treatment: Includes: providing health care to a client, coordinating and/or managing a client's care with a third party, consulting with another provider, and referring a client to another provider.

Payment: Includes: determining eligibility for benefits, billing and claims management, health care data processing, and other activities with another entity which is also subject to federal privacy laws. For example, your insurance and/or managed care provider, or a government entity, such as worker's compensation, Medicaid, Medicare, or other similar program.

Health Care Operations: Includes: quality assessment; case management and care coordination; peer review, accreditation and licensing; conducting or arranging for medical review, legal services, and auditing functions; customer services; business management; and other activities.

WHEN YOUR EXPLICIT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION IS REQUIRED

Upon your explicit authorization, either verbally or in writing, you or your personal representative (for example, parents, power of attorney, etc.), may give us authorization to use or share your PHI to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization with it was in effect. When you provide us with an authorization for another party to receive information about you, we have the right to review, approve and/or reject your authorization request as per our internal procedures. In addition, you must provide us with an authorization for us to request PHI about you with another party.

Family, Friends and Others: Only upon your explicit authorization, either verbally or in writing, may we share your PHI to a family member, friend, or personal representative, to the extent necessary to help with your health care or with obtaining payment for your health care. However, if you are incapacitated, and the situation indicates that disclosure would be in your best interest (for example, to an emergency medical service provider), we may share your PHI to a family member, friend or other person to the extent necessary to help with your care.

Research and Marketing: We do NOT use or disclose PHI information for research or marketing purposes.

Other Limitation on Disclosure: Generally, we do not disclose PHI to third parties, except in extenuation circumstances, such as:

Public Health and Safety: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We will disclose your PHI to a government agency authorized to oversee the health care system and or government programs or its contractors, and to public health authorities for public health purposes. If you are a minor, we will disclose your PHI to the appropriate authorities if we believe that you are a possible victim of abuse, neglect, domestic violence or other crime.

Required by Law: We will disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the proper authorities for purposes of determining whether we are in compliance with federal privacy laws.

Process and Proceedings: We must disclose your PHI in response to a court order. However, we must obtain a written authorization in order to disclose your PHI in response to an administrative order, subpoena, discovery request, warrant, officials, or other lawful process.

Law Enforcement: We will not disclose information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person, except in those instances referred to elsewhere in this Notice (for example, by court order, in cases of possible harm to self or others, etc.).

Military and National Security: We will not disclose to military authorities the PHI of Armed Forces personnel except in emergency situations where authorized federal officials require PHI for lawful intelligence, counterintelligence, and other national security activities, and they have produced a court order. In all non-emergency matters (for example, job reference/background checks), we must obtain a written authorization from you to release your PHI.

Other Limitations on Disclosure: We do not disclose to third parties information which would identify a client who has received treatment for substance abuse or HIV, without your, or your personal representative's, verbal or written express authorization.

Individual Rights

Access: You have the right to look at or get copies of your PHI, with limited exceptions. If you request copies, we will charge you a reasonable cost-based fee to copy your PHI and postage if you want the copies mailed to you. If you request, we may prepare a summary or an explanation of your PHI for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities. This may include disclosures made within six (6) years prior to your request, excluding anything prior to April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our Agreement (except in an emergency).

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or at an alternative location, if you feel endangered. You must inform us that confidential communication by alternative means or at an alternative location is required to avoid endangering you. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or location you want. We must accommodate your request if it is reasonable, specifies the alternative means of location, and continues to permit us to perform health care operations, defined above.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it should explain why the information should be amended. We may deny your request if we did not create the information you wanted amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding your individual rights, you may file a complaint with our Privacy Officer using the contact information listed at the beginning of this notice. You may also submit a written complaint to the US Department of Health and Human Services.

For more information: Federal Register, 12/28/00-HIPAA Privacy Rule 45 CFR 160 & 164. (Modifications 8/14/02)

I have read and understand this Privacy Statement:

X _____

Date: _____

Hinkle Counseling & Psychological Center, LLC
519D, East Main St., Bridgeport, WV 26330
(304) 848-0660
PATIENT FINANCIAL RESPONSIBILITY STATEMENT

The psychological services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving services from Hinkle Counseling & Psychological Center, LLC ("HCPC"), you agree:

You acknowledge and agree to the established policies and procedures of HCPC, including but not limited to this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, in effect from time-to-time ("Policies"). You may request a copy of the current Policies from your provider. These Policies may be changed from time to time by HCPC, without notice. If there is any conflict between another policy or procedure of HCPC and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, this Statement shall control.

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our Policies, which are not otherwise covered by supplemental insurance.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at HCPC, and you have not obtained such authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at HCPC are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at HCPC; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by HCPC.

By signing below, you authorize HCPC to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to HCPC, for application onto your bill for services, all under federal or state healthcare plan, insurance policy, any managed care arrangement or other similar third-party-payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize HCPC to release patient information (for example, DSM-V diagnoses, date of service) acquired in the course of your treatment that is deemed necessary to process this claim to the necessary insurance companies or third-party payors. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. HCPC does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to HCPC until your patient account is paid in full.

You will be mailed a billing statement that contains the total cost of your service(s) received during your visit(s). You must notify us of any errors or objections to the billing statement. If there is a problem with your account, it is your responsibility to contact HCPC to address the problem or to discuss a workable solution.

Whether or not you have insurance or are self-pay, payment of any account balance is due within (30) days of receipt of your billing statement. If any balance on your account is over (90) days past due, your account will be in default and auto referred to a collection agency. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower.

We accept payment by check, cash, debit cards or credit cards.

Payment by Check. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of \$20.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

Payment by Credit Card/Debit Card. You may pay with a credit card or debit card, including Visa, Mastercard, and Discover ("credit card"). Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement. All regular credit card rules will apply. Once authorization on the submitted information is received, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment.

Managed Care (HMO, PPO, etc.). All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization for a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

Workers' Compensation Cases. Charges for services incurred as a result of a certified work-related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within (30) days.

Third Party Liability Injuries. If you receive treatment as a result of a third-party liability injury, the balance for services rendered is considered due in full at the time of service. Because HCPC does not protect charges incurred related to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from any attorney as a guarantee of payment or assignment of third-party insurance payments. HCPC cannot act as administrator to resolve financial arrangements. We may agree to bill a third-party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the third-party carrier. We will also collect information about your personal medical insurance in case the third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

Additional Charges. Patients may incur and are responsible for the payment of additional charges at the discretion of HCPC including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without 24 our advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.

Non-payment on Account. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that HCPC has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care. By signing below, you agree, on behalf of yourself, your legal representatives and next of kin, that the jurisdiction, venue and choice of law of any dispute or state court action related to the health care services or the billing provided by HCPC shall, at the option of HCPC, be subject to the exclusive jurisdiction of (i) the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered or (ii) where you reside.

Minor Patients. The parent/guardian of a minor is responsible for payment of the minor's account balance. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of HCPC.

Authorization to Contact. You authorize HCPC personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. HCPC, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail address, cell phone numbers, and landline numbers to contact you for purposes related to your account, including debt collection. You authorize HCPC to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

ACKNOWLEDGEMENT

By signing below, each of the undersigned acknowledges that (i) I have been provided a copy of the HCPC PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understood, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to HCPC for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any paid by third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collection the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as a valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC ("PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____/_____/_____
Patient/Responsibility Party/Guardian Date Date of Birth

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of services and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____/_____/_____
Signature of Patient or Guardian Date

Hinkle Counseling & Psychological Center PLLC., 519 E. Main St., Ste. D, Bridgeport, WV 26330
Insurance & Financial Information

Primary Insurance Co: _____ **Insurance Phone:** _____

Name of Person Holding **Primary Insurance:** _____

Member ID: _____ Group #: _____

Relationship of Policy Holder to you: _____ DOB of policy holder: _____

Address of Policy Holder: _____

Secondary Insurance Co: _____ **Insurance Phone:** _____

Name of Person Holding **Primary Insurance:** _____

Member ID: _____ Group #: _____

Relationship of Policy Holder to you: _____ DOB of policy holder: _____

Address of Policy Holder: _____

*Hinkle Counseling & Psychological Center, PLLC
Credit Card Payment Consent Form*

Client Name: _____

Name on Card if Different: _____

By signing the "Patient Financial Responsibility Statement", I have authorized Hinkle Counseling & Psychological Center, PLLC to charge my credit card for professional services as follows:

- The Balance on my account after insurance has been billed.**
- Late Cancellation Fee.**
- No Show Fee.**
- Co-pay.**

Circle One: VISA MASTERCARD DISCOVER

Card Number: _____ **Security Code:** _____

Expiration Date: _____ **Zip Code:** _____

Mailing Address: _____ **City:** _____ **State:** _____

Cardholder's Signature: _____ **Date:** _____