LODESTONE

CENTER FOR BEHAVIORAL HEALTH

Client Registration Form: (Minor)

Child's Information:

Client's Full Name:_____ Date of Birth: ____/____/____

Gender: _____ Client's SSN: _____ *Used for Insurance Reasons*
See next page for mailing address

Guardian (and Emergency)* Contact Information:

Note: The Guardian Contact also serves as the client's Emergency Contact

Unless otherwise specified below, by providing phone numbers and emails you are giving permission for The LodeStone Center for Behavioral Health to leave voicemails and contact you via email. For additional information on email communication and privacy, please see our privacy policy.

Name of Guardian:_____ Relationship:_____

Cell: (*Default*) _____ Home:_____ Work: _____

Email Address:_____

Optional: Do Not Leave Voicemails on the following phone number(s): _____

Appointment Reminders:

Appointment reminders are provided by our Electronic Medical Records (EMR) system. When your appointment is scheduled, the computerized system is able to send out a reminder 24 to 48 hours in advance. By completing this section, you acknowledge that information through email or text is not necessarily secure and we cannot guarantee that someone else will not access information regarding your appointment through these means.

☐ I prefer not to receive reminders.

If you do prefer to receive reminders, please check the box that applies:
(Options below are the options provided by our EMR System).

☐Email Only ☐Text Only ☐Text and Email ☐Text or Call, and Email

If the child has her/his own cell phone and would like a reminder to that phone number as well, please list that number and reminder type below:

Cell: _____ Email: _____

☐Email Only ☐Text Only ☐Text and Email ☐Text or Call, and Email

Additional Contacts: (Optional)

Primary Care Doctor Name:_____Phone:_____
May we contact this person regarding your care here? ☐ Yes ☐ No

Psychiatrist Name:_____ Phone:_____
May we contact this person regarding your care here? ☐ Yes ☐ No

Other Professional Contact: _____ Phone:_____
May we contact this person regarding your care here? ☐ Yes ☐ No

Financial Responsibility Agreement:

Because the Client is a minor (person under the age of 18), it is expected that a guardian or parent be responsible for payment of services. Please indicate the person responsible for payment of the client balance. Please understand that we cannot assign financial responsibility to persons not present to sign this document. Therefore, the person responsible for payment may differ from the insurance holder. If you have any concerns regarding court or custody agreements, please refer to the "Special Circumstances" Section of this document. Thank you.

Party Responsible for Patient Balance:

Person listed must match signature at end of form

Full Name:_____ Date of Birth: ____/____/____

Gender: _____ SSN: _____ - _____ - _____ Relationship to Patient: _____

Mailing Address & Apt #:_____
I understand that by giving this address, statements and necessary forms will be mailed to the address provided.

City:_____ State:_____ Zip Code:_____
☐ Address has been verified by USPS.com/zip4 (Office Use)

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Other _____

The LodeStone Center for Behavioral Health reserves the right to charge for services rendered by any practitioner employed by The LodeStone Center for Behavioral Health. Please see the different sections below to indicate how payment will be collected and services will be billed. For any questions regarding this section, please contact our Billing Department.

Payments and Billing:

If you are 18 years of age or older, unless other signatures are provided, statements and financial responsibility will default to you.

Billing for services rendered is handled in-house by our Billing Department. Client Statements are sent out once a month to the address provided in the responsible party information section above. For privacy reasons, we do not fax or email statements unless specifically requested as a one-time courtesy. We expect co-pays at time of service, and any co-insurance or deductible to be paid within the billing cycle after your Explanation of Benefits (EOB) is received. To maintain a manageable client balance, the front office personnel or your therapist may ask you to pay on your co-insurance or deductible at time of service. We accept payment via credit card, cash, or check at all locations, or by credit card over the phone.

Use of Insurance Plans:

By signing this form, you acknowledge that your insurance coverage, notification of any pre-authorization requirements, and terms of coverage are ultimately your responsibility. This information should be provided to

the office *before your first appointment*. If it is not provided, you understand the risks involved with billing unverified services to the insurance company and may be liable for the full amount of services at the company rate. This requirement is intended for your benefit and allows you to receive the full amount of services available. If the requirements above are met, but your insurance provider rejects services, you may still be responsible for payment of services provided. If requested, we would be happy to update you on the reimbursements received from your insurance company.

If the **Insurance Holder** is different that than the Responsible Party previously listed herein, please provide the information here:

Full Name:_____ Relationship to Client:_____

Mailing Address & Apt #:_____

City:_____ State:_____ Zip Code:_____

Date of Birth: ____/____/____ Gender: _____ Phone Number: _____

Cancellation Policy:

By signing this form, you acknowledge that by scheduling an appointment, your provider reserves time specifically for you, your child, or your family. This time is set aside and prevents others from scheduling during your reservation. We request a minimum of 24 hours' notice for any cancellations or reschedules. Because of the time set aside, if proper notice is not given for rescheduling or cancellation, a **cancellation fee of $50.00** will be applied to your account. Insurance does not cover missed appointments. Please be aware that a failure to receive a reminder does not waive this cancellation fee. You are still responsible to remember your appointment date and time.

Special Circumstances:

We make every effort possible to respect the wishes of our clients. However, **The LodeStone Center for Behavioral Health is not responsible for maintaining financial arrangements made between separated or divorced parents or couples under any circumstances.** If there is a financial agreement between such parties, we respect your privacy, and require that you manage those arrangements. *For financial responsibility in these types of cases, the person whose signature is on file on the registration paperwork is deemed the party responsible for payment.* We cannot acknowledge financial responsibility for a party who is not present to agree to the terms provided. (Statements can be provided upon request for proof of payment in order to submit to other parties).

Past Due Balances:

By signing this document, you acknowledge that unpaid balances of a 90 days past due status can automatically be charged to your credit card on file. If balances are not charged, we reserve the right to utilize collection agency services. We make every effort to work with clients and provide ample time and opportunity for payment. Payments are accepted in person, by mail, and over the phone. Additionally, payment plans are offered upon request.

CONSENT TO TREATMENT:

By signing this document, you agree to the following statements:

I agree to participate in treatment and understand that a positive outcome cannot be guaranteed. I understand that working with my practitioner in identifying therapy goals is in my best interest and I agree to be an active

participant in working towards these goals. I also understand that there are some instances that therapy could worsen my symptoms, and participation does not guarantee that my symptoms or concerns will be resolved.

CONFIDENTIALITY AND PRIVACY:

I have read and agreed to the Privacy Notice (HIPAA Statement) provided to me. I understand that I can obtain a printed copy from the staff, and can ask for clarification on any policies stated in it.

I** (print name) _____**have read and understood the above conditions of this document, and agree to them. I have asked any questions I am concerned with and understand the policies outlined above.

x _____ Date:_____
(Signature of Responsible Party)

x _____ Date:_____
(Signature of Client, if 12 years or older)

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CENTER FOR BEHAVIORAL HEALTH

PRIVACY NOTICE

Notice of The LodeStone Center for Behavioral Health, PC policies and practices regarding protecting and disclosing personal healthcare, psychological and medical information.

This document describes how your personal healthcare information (referred to as PHI) may be used or disclosed, and how you may obtain access to it. Your therapist can answer any specific questions you may have about how these policies and procedures apply to your private information.

Use and Disclosure of Information for Treatment, Payment and Health Care Operations

Treatment:

Your personal information is used to provide your treatment, and to coordinate care with other healthcare professionals or related entities (such as hospitals, primary care doctors or other mental healthcare professionals). This includes instances where your therapist may consult with another licensed professional (usually our clinical staff) for purposes of planning and implementing your treatment.

Payment:

Your private information is used to obtain payment for the services provided to you. If you have requested the use of your health insurance, your information will be released to your health insurance company. This includes information to identify you, and information regarding your treatment, such as your diagnosis.

Payments for services that are the responsibility of the patient, or patient's guardian are due at the time services are rendered. Patients who utilize health insurance are responsible for the portion of the fees agreed to in their specific policy (this may be a co-pay, coinsurance, deductible, or the portion of fees not covered when the therapist is not under contract with your insurance company). We send bills to you for outstanding balances every month, to the address provided to us on your registration form. **Balances that are more than 90 days late may be submitted to a collections agency outside of The LodeStone Center for Behavioral Health.** You will be notified in writing, by mail prior to having your balance submitted for collections. We do not submit accounts to collections when the responsible party has requested payment arrangements, and is paying the balance according to those arrangements. Such arrangements can be made by calling our administrative staff.

Healthcare Operations:

Your information is used in the regular operations of The LodeStone Center for Behavioral Health. This includes activities such as scheduling your appointments, processing and submitting insurance claims, coordinating your care with other facilities. In these operations, our administrative staff can access the information from your records needed to process insurance claims and authorization, payment, or coordination of care. We have a policy that only licensed clinical staff may access the section of your records pertaining to your treatment (such as your evaluation report and "progress notes").

Instances in which your information may be disclosed without your consent:

- *Child Abuse* – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – If we have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.

- *Health Oversight Activities* – we may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to our staff a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

- *Worker's Compensation* – We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient Rights

Revocations, amendments and restrictions to authorization for disclosing your information must be submitted in writing, so that it can be documented in your record. If we have already disclosed or relied on that authorization, we may not be able to comply with the requested change.

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your written request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, we will discuss with you the details of the request for access process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, your therapist will provide you with a revised notice.

Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact the clinical director.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Clinical Director, The LodeStone Center for Behavioral Health, 111 Dean St., Woodstock, IL 60098.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. The LodeStone Center for Behavioral Health, PC will not retaliate against you for exercising your right to file a complaint.

Effective Date, Restrictions, and Changes to Privacy Policy

This notice was revised and will go into effect on December 13, 2018.

By signing, I attest that I have read and agree to the terms described in this notice. I also understand that I can obtain a copy of this document by requesting it from the staff at The LodeStone Center for Behavioral Health, my therapist, or by downloading it from the clinic website.

X_____ Date: _____

Signature of Patient (12 yrs & older)

X_____ _____

Signature of Parent or Guardian/Parent:
(For any patient under 18 yrs. Old)

Name of Guardian/Parent

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CONSENT TO TREAT MINOR

I, _____ am the parent or legal guardian of _____
(print parent / guardian name) (print child name)

By consenting to have my child involved in therapy services, I understand that there may be some aspects of therapy that I will not have disclosed to me for the sake of building trust with my child, and depending on the age of my child, there are some aspects of therapy that I will not legally have access to without my child's consent. This excludes information related to threats to safety.

I also understand that my therapist is a mandated reporter of suspected child abuse (which can include instances other than physical harm or injury). In the event my therapists suspects that child abuse has occurred, the incident will be reported to the appropriate child and family protection agency. I will be notified of such a report, and if I am available to do so immediately, I may be allowed to make the report myself, with my therapist present.

I understand that I have a right to obtain certain treatment information at any time by law, such as diagnosis, services rendered, treatment plan, etc. This may not include certain details regarding the content of therapy. Any other parent or legal guardian (even if not living with the child) may have similar rights.

I understand that involving my child in therapy does not qualify as a custody evaluation in divorce proceedings. Custody evaluations require a very specific type of procedure and qualified professional, and my therapist's impressions will not be sufficient for this purpose.

By signing this document, I consent to my child's participation in treatment, and affirm that I have the legal authority to give such consent.

_____ _____
Signature of Parent or Legal Guardian Date

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Credit Card Authorization

Client Name: _____ Date of Birth:_____

The information gathered below is used for the purpose of co-pays/deductible payments/co-insurance payments incurred at The LodeStone Center for Behavioral Health at time of service. Please complete the form below and choose the best option for your account. If you prefer your card not be saved, please check *Do Not Save My Credit Card Information*, and Initial, with the date.

OPT OUT:
☐Do Not Save my Credit Card Information. X _____ Date: _____

OPT IN:
☐Please, save my card on file, but do not run it without my verbal permission.

☐Please, put the following information on file to run at time of service.

Card type(Circle One): Visa/MC/Amex/Discover

Cardholder Name: _____ Phone Number: _____

Card Number: _____ Expiration Date: _____ /_____

Security Code: _____ Billing Zip Code: _____

Cardholder Signature: _____ Date: _____

By signing, you are providing permission for payments to be drafted from your account (when verbally indicated during appointment check-ins, or otherwise agreed upon) and applied toward the above person's account.