STERLING BEHAVIORAL HEALTH ASSOC. PLLC

DATE OF INTAKE ______ / ______ / ___________

Please fill in all information as accurately as possible. All information is confidential.

PATIENT INFORMATION

FIRST NAME ____ MI _______

LAST NAME ____

DOB ______ / ______ / ___________ M ____ F ____

RELATION TO INSURED SELF ____ SPOUSE ____ CHILD ____

ADDRESS ____

CITY _____________________________________ STATE _______________ ZIP _________________

PHONE ___________________________________

EMAIL ____

Do you consent to being contacted via mail, phone, text or email? YES ____ NO ____

PURPOSE OF VISIT ____

EMERGENCY CONTACT ____

RELATION _________________________________ PHONE ___________________________________

CONSENT TO NOTIFY EMPLOYER OF EMERGENCY? YES ____ NO ____

EMPLOYERS NAME ______________________________ PHONE ______________________________

INSURANCE INFORMATION

INSURANCE CARRIER _____________________________________ COPAYMENT ______________

ID# ____

GROUP# ____

POLICY HOLDER ____

MEMBER DOB ______ / ______ / ___________ M ____ F ____

(Complete below if different than address of patient)

ADDRESS ____

CITY _____________________________________ STATE _______________ ZIP _________________

PHONE ___________________________________

PATIENT HISTORY

PHYSICIAN/PSYCHIATRIST NAME ____

PHONE ___________________________

MEDICATION ____

Have you been to counseling before? YES ____ NO ____

FAMILY HISTORY

Please list all members in your household:

	NAME/RELATION	AGE	DOB		
1.	____________________________	______	_____ / _____ / _____	M ____	F ____
2.	____________________________	______	_____ / _____ / _____	M ____	F ____
3.	____________________________	______	_____ / _____ / _____	M ____	F ____
4.	____________________________	______	_____ / _____ / _____	M ____	F ____
5.	____________________________	______	_____ / _____ / _____	M ____	F ____

NAME OF RESPONSIBLE GUARDIAN ____

RELATION ____

PHONE ___________________________

(Complete below if different than address of client)

ADDRESS ____

CITY ____________________________ STATE ___________ ZIP _____________

FINANCIAL / INSURANCE ISSUES

As a courtesy, we will bill your insurance company, responsible party or third-party payer if you wish. Your co-payment is required at each session. In the event that you have not met your deductible, the full fee of **$150** is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, you are required to pay the balance at that time. At thirty (30) days after the session, the unpaid balance will be charged 1.5% interest/month. In the event that an overdue account is turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of behavioral health benefits directly to Sterling Behavioral Health Associates PLLC

INITIAL _______

CANCELATION OF APPOINTMENT

We ask that you provide a **48-hour notice of cancelation**. Sterling Behavioral Counseling has a 24-hour answering machine to assist you in cancelation and rescheduling. Failure to provide notice will result in a cancelation fee of **$60**

LETTER / PAPERWORK FEE

A **$65** fee will be assessed for correspondence required for legal matters including, but not limited to: documentation for court, CPS, or attorneys. Additional fees may apply for other paperwork requested, appearances in court, or other entities.

INITIAL _______

TERMINATION OF COUNSELING

Discussion and action toward counseling termination and/or referral will be conducted when:

1. Counseling Treatment Plan Goals have been achieved.
2. You no longer want counseling or do not return for counseling.
3. You are no longer benefiting from counseling.

Your signature below indicates you have read and understand this policy.

____ ____________________

PATIENT / LEGAL REPRESENTATIVE SIGNATURE DATE

____ ____________________

PRINT NAME DATE

STATEMENT OF FINANCIAL RESPONSIBILITY AGREEMENT OF BENEFITS

I acknowledge that I am legally responsible for all connection with the mental behavioral care and treatment provided by Linda Sterling at Sterling Behavioral Health Associates PLLC. I assigned and authorize payments to Sterling Behavioral Health Associates PLLC. I understand my insurance carrier may not approve or reimburse my mental behavioral services in full due to usual and customary rates, benefits exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductions, and co-insurance exempt where any liability is limited by contract or State and Federal Law.

____ ____________________

PATIENT / GUARDIAN SIGNATURE DATE

____ ____________________

PRINT NAME RELATION TO PATIENT

INFORMATION PROFESSIONAL SERVICE INFORMED CONSENT

Thank you for choosing Sterling Behavioral Health Associates PLLC. Today's appointment will take approximately 45-50 minutes. We realize that coming to counseling is a major quality decision and you may have many questions. Today's session will include an intake which will include questions in order to collaboratively develop a treatment plan which will include developing measurable goals for your therapy. This document informs you of your rights, our policies, state and federal law. If you have other questions or concerns, please feel free to ask during your sessions.

CONFIDENTIALITY

You have the right to confidentiality. No information will be released without your written consent except as requested by law. Such exceptions to confidentiality include:

- We believe you are in imminent danger of hurting yourself or others.
- By Texas State Law, we are obligated to report information concerning child and/or elder abuse to the department of Children and Family Services.
- We are required by law to release information such as a court ordered subpoena.
- We may need to disclose information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes.

Under the Health Insurance Portability and Accountability Act (HIPAA), you have certain rights to privacy regarding protected health information. You have been given the HIPAA requirements concerning privacy policies. This information can and will be used to:

- Conduct, plan, and direct treatment and the possible follow-up among the healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and integrated healthcare.

EMERGENCY CONTACT

At Sterling Behavioral Health Associates PLLC, we do not provide crisis interventions or intensive crisis counseling. If you have a crisis after office hours, please contact your physician, contact the crisis hotline at **National Suicide Prevention Lifeline at 988, Texas Hotline at 832-416-1177, Teen line at 832-416-1199 or 800-852-8336** and/or go to the nearest emergency room. If hospitalization occurs, please contact our office during business hours.

______________________________________ ____________________

PATIENT / GUARDIAN SIGNATURE DATE

PATIENT RIGHTS AND HIPPA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office Initiated this authorization, you must receive a copy of the signed authorization.
6. Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the clients medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy notes" definition is the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, and the treatment plan, symptoms, prognosis, and progress to date.
7. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of "Psychotherapy Notes" must sign this authorization to specifically allow for the release of "Psychotherapy Notes." Such authorization must be separate from an authorization to release other medical records.

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PATIENT / GUARDIAN SIGNATURE DATE