NEW PATIENT INFORMATION

Today's Date _____

PATEINT INFORMATION

Patient's Name _____

Date of Birth _____ Social Security # _____ Sex _____

Address_____

City _____ State _____ Zip _____

Primary phone # _____ Secondary phone # _____

Email _____

Preferred method for reminders (select one) ◯ voice ◯ text at # _____

Employer _____ Work phone # _____

Emergency contact _____Phone # _____

RESPONSIBLE PARTY INFORMATION (for minors)

The information below MUST match the signer of these documents.

Responsible Party's Name _____

Date of Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Primary phone # _____ Secondary phone # _____

Employer _____ Work phone # _____

Relationship to the patient _____

ADDITONAL INFORMATION

Have you been in counseling in the past? ◯ yes ◯ no If yes, with whom? _____

How did you hear about our office? _____

*****Please include a copy of the front and back of 1) your identification card and 2) your insurance card*****

FINANCIAL AGREEMENT

◯ INSURANCE

Please be informed that True Joy Counseling and Consulting, PLLC (TJCC) files for PRIMARY INSURANCE as a courtesy and it is no way a guarantee that your insurance company will pay for services rendered. All claims are subject to the conditions of your policy. You, as the patient, are ultimately responsible for your account and any follow-up needed with your insurance carrier as their beneficiary. Your signature below is required in order for TJCC to file your insurance and for you to receive services.

PRIMARY Insurance Company Name _____

Policy Holder Name _____ DOB _____

ID# _____ Group # _____

◯ SELF-PAY

Responsible Party Name: _____

Relationship to Patient: _____

I certify that I have read the policy above and I am eligible for the insurance indicated on this form and/or I will self-pay for services. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to True Joy Counseling and Consulting, PLLC (TJCC) all money to which I am entitled for medical/behavioral health expenses related to the services performed at TJCC, not to exceed total charge. I authorize TJCC to release any medical/behavioral health information to my insurance carrier or third-party payer to facilitate the processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due may result in submission to an outside collection agency. I choose to receive communications from TJCC by text or voicemail at the number or address stated above, including but not limited to communications about appointments and/or payment. I understand that such communications may not be secure and there is a risk that they may be read by a third party.

Electronic Submissions: Typing your name on the signature line below constitutes a legal signature confirming that you accept the agreement above.

Patient's Name _____ Date _____

Pt/Parent/Guardian/Responsible Party Signature _____

LETTER OF UNDERSTANDING and INFORMED CONSENT

1. ***SERVICES*** – Services are delivered by Independent Contracted Providers including Clinical Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and Licensed School Psychologists. Providers are trained professionals providing mental health care services and will discuss the various aspects of psychotherapy, this includes discussions regarding evaluation and diagnostic formulation, method of treatment, the nature of treatment, possible side effects, and possible alternative forms of treatment.
2. ***IDENTIFIED PATIENT & PATIENT INFORMATION*** – The identified patient and/or collateral individual(s) to the identified patient should attend scheduled therapy sessions. The identified patient and/or guardian is responsible for letting the practice know of any changes to information as soon as practical. Please update information as it arises.
3. ***CONFIDENTIALITY*** – Information is only released after you have given permission by signing a release form, however, there may be certain times that we would be required by ethics and law to break confidentiality. Those situations are (a) when there is an immediate threat of suicide or homicide, (b) when there is suspected or actual abuse and/or neglect of a child, the elderly, and/or an individual with disabilities, and (c) legal court orders to provide information.
4. ***TELEHEALTH*** – Telehealth, or the use of electronic communication to remotely provide clinical care services, may be utilized at your request or by your provider's request. Please see the attached Telehealth Informed Consent.
5. ***GOALS & TREATMENT*** – There may be multiple interventions to effectively treat the problems that you are experiencing. It is important for you ask any questions you may have regarding the treatment recommended by your provider and to provide input in setting goals in your therapy. As therapy progresses, your goals may change.
6. ***INSURANCE & PATIENT RESPONSIBILITY*** – Primary insurance, in which providers are in-network, will be filed as a courtesy to you and assignment accepted. Deductibles, co-insurance, shared costs, and/or co-pays are due at the time of service. Secondary insurance is not processed or filed.
7. ***PROFESSIONAL FEES*** – Fees for psychotherapy and/or consulting are $200 for a 55-minute session, $175 for a 45-minute session and $150 for a 30-minute session.
8. ***TELEPHONE CONSULTATIONS*** – Phone consultations with you, your physician, and/or other clinicians are not covered by your insurance. These fees are your responsibility and will be charged in 15-minute increments at the rate of $200.00 per hour.
9. ***PAYMENTS*** – Payment is due at the time of service and a credit card must be placed on file with our office. Please see the attached Credit Card Consent Form. Your credit card is maintained in a secure and confidential system and will be processed when your balance reaches $100. Your credit card will be processed for fees including professional fees, telephone consultations, co-pays, cost-share, co-insurance, no show fees, and/or late cancellation fees. Payments by check are also accepted. Returned checks will be assessed a $20 office administrative fee, as well as any bank fees charged. Failure to pay could result in being referred to collections if efforts to collect the balance have failed. By signing this agreement, you acknowledge responsibility of debt and agree to a limited waiver of confidentiality allowing disclosure of your information to a collection agency/attorney only to the extent sufficient for collection purposes.
10. ***OFFICE HOURS & PHONE CALLS*** – Our office hours are 8:00 A.M. to 5:00 P.M. Monday through Friday. Our staff takes lunch from 12:00 P.M. to 1:00 P.M. If you call our office and get a recording, please leave a message on our confidential voicemail.

11. ***CRISIS & EMERGENCY*** – If you cannot call during our normal business hours and you are in crisis, call the crisis line at 244-9191. In life threatening situations call 911 or go to the nearest emergency room for immediate care.

12. ***APPOINTMENTS & CANCELLATIONS*** – In the event you cannot keep your appointment, a 24-hour notice is required by calling our office. If you do not cancel your appointment, you will be charged a $100 fee. If you have several standing appointments and you miss two consecutive sessions without contacting our office, all future appointments may be cancelled. If keeping your scheduled appointments becomes problematic, you will be asked to pre-pay for your sessions and the payment will be applied to appointments or other fees owed. As a courtesy, we use a computerized appointment system to notify you of appointments, but ultimately you are responsible for maintaining your appointment schedule. Consideration will be given for illness and emergencies.

13. ***OFFICE POLICIES*** – A copy of our office policies and practices are available in the office and posted for your review on our web site, TrueJoyCounseling.com. Please read the policies thoroughly regarding the privacy of your personal health information and other practice guidelines.

14. ***LEGAL PROCEEDINGS*** – Contents and documentation of any individual, joint, and/or family psychotherapy session by the patient or their family member(s) are ***not*** to be used in any divorce, separation, child custody, and/or any other legal proceedings. Patients understand and agree that True Joy Counseling & Consulting providers will not participate in any legal proceedings based on information obtained during or concerning psychotherapy.

15. ***PROVIDER'S INCAPACITY OR DEATH*** – In the event your provider becomes incapacitated or dies it will become necessary for another provider to take possession of patient records. By signing this agreement, you give consent to another licensed mental health professional at True Joy Counseling to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

16. ***TERMINATING TREATMENT*** – You have the right to discontinue therapy at any time. Please let your provider or our office know as soon as possible. If at any point during treatment your provider assess that therapeutic goals are not being met, you are non-compliant, or you are non-responsive in treatment to manage your care, then treatment may be terminated. You will receive written notification of termination of treatment.

WE LOOK FORWARD TO A SUCCESSFUL THERAPEUTIC RELATIONSHIP WITH YOU.

I certify that I have read and agree to the Letter of Understanding and I, the undersigned party, do hereby give my consent to the TJCC Independent Contracted Provider, in the capacity of psychotherapist and/or clinical psychologist, for treatment.

Electronic Submissions: Typing your name on the signature line below constitutes a legal signature confirming that you accept the agreement and consent above.

Patient's Name _____ Date _____

Pt/Parent/Guardian/Responsible Party Signature _____

TELEHEALTH INFORMED CONSENT

I hereby consent to participate in telehealth as part of my psychotherapy and psychological services. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a provider and a patient/client who are located in two different locations.

I understand the following with respect to telehealth:

1. I understand I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. I understand there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse, danger to self or others).

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I will exit the platform, log back in, and restart the session. If we are unable to reconnect within ten minutes, please call me at (_____)_____ and discuss the remainder of the session or how to re-schedule.

7. I understand my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8. **Emergency Protocols:** Your provider will need to know your location in case of an emergency. You agree to inform them of the address where you are at the beginning of each session. A contact person, who can be reached on your behalf in a life-threatening emergency only, is required. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. **In case of an emergency,**

   my location is: _____

   My emergency contact person's name, address, phone: _____

   _____

I certify that I have read and agree to the Telehealth policy and I, the undersigned party, do hereby give my consent to the TJCC Independent Contracted Provider, in the capacity of psychotherapist and/or clinical psychologist, for telehealth treatment.

Electronic Submissions: Typing your name on the signature line below constitutes a legal signature confirming that you accept the agreement and consent above.

Patient's Name _____ Date _____

Pt/Parent/Guardian/Responsible Party Signature _____

CREDIT CARD CONSENT and AUTHORIZATION FORM

I hereby consent and authorize True Joy Counseling and Consulting, PLLC to capture my credit card information and securely store my credit card on file.

1. I give my expressed permission for any fees, including professional fees, telephone consultations, co-pays, cost-share, co-insurance, no show fees, and/or late cancellation fees incurred by the patient listed below to be charged to my credit/debit card (information below) for services at True Joy Counseling and Consulting, PLLC.

2. I understand that my credit card will be processed when my balance approaches $100 or more.

3. I understand and agree that if my credit card is declined for any reason, I will pay with another credit card or may be asked to pay with cash or check.

4. I understand that a credit card issued by a Health Savings Account (HSA) can only be used to pay for qualified medical expenses. If an HSA card is listed below, I will pay for all other non-qualified medical expenses including, but not limited to telephone consultations, no show fees, and/or late cancellation fees, with another credit card or may be asked to pay with cash or check.

5. I understand that this form is valid until I give a 30-day written notice to cancel the authorization to True Joy Counseling and Consulting, 1041 John Sims Parkway East, Niceville, FL 32578.

Credit Card Information	
Card Type: ☐ Visa ☐ Master Card	
Card Holder's name (as shown on card)	
Card Number (16 digits)	
Expiration Date (mm/yy)	CSC/CVV Code (3 digits on back)
Card Holder's Zip Code (credit card billing address)	

I certify that I have read and agree to the Credit Card policy. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Electronic Submissions: Typing your name on the signature line below constitutes a legal signature confirming that you accept the agreement and consent above.

Patient's Name _____ Date _____

Pt/Parent/Guardian/Responsible Party Signature _____