Counseling Registration Form

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Client's Name _____ Date_____

Street Address: _____ D.O.B._____

City, State, Zip: _____

Sex: Male_____ Female_____

Individual completing form (Relationship):_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____

Primary Language spoken in home: _____

Please check Yes__ or No___ to receive emails regarding therapy services.

Is it ok to send appointment reminders to cell phone? Yes___ or No___

Referred By:_____

Primary Care Physician Contact Information

Primary Care Doctor:_____

Phone Number:_____ Fax Number:_____

Address:_____

State:_____ Zip Code:_____

Medical History:

How would you rate your current physical health? Please circle one.

_____Poor _____Unsatisfactory ____Satisfactory _____Good _____Very Good

Please list any specific health problems you are currently experiencing:
_____

_____

_____

_____

_____

How would you rate your current sleeping habits? _____Poor____ Unsatisfactory ____Satisfactory ____Good ____Very Good

If you are having problems, in which phase of sleep are you experiencing issues? ___Falling asleep _____Staying asleep____ Awakening early____ Sleep apnea

How many times per week do you exercise? _____

Are you currently experiencing any chronic pain? _____ If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:
_____
_____
_____
_____
_____
_____

History of allergies, tonsillitis, or asthma? ____yes____no
Are there any diagnosed medical, physical, or emotional problems?____yes_____no
Have there been any serious illnesses, injuries, or hospitalizations? ____yes____no

If you answered yes to any of the questions above, please explain and give dates:____
____
____
____

Health Insurance Information-Primary Health Insurance

(Copy of Card Front &Back Required)

Patient's Name _____________________________D.O.B.______________

Parent/Guardian:_____________________________________Phone_____________________

Address:_____________________________City__________________State______Zip_______

Medicaid #:_______________________Circle One (Amerigroup, CareSource)

Primary Insurance:_________________________________

Policy Holder:_________________________________ Policy Holder Date of Birth:_________

Policy ID#______________________Group#________________Plan Name_______________

Employer____

****

Secondary Insurance :_________________________________

Policy Holder:_________________________________Policy Holder Date of Birth:_________

Policy ID#_______________ Group#_____________Plan Name _______________________

Cancellation and No Show Policy

Attendance/Cancellation Policy

Your therapy is especially important, and **Milestone Behavioral Health Services, LLC** wants to provide the most effective services to all clients. We are committed to helping improve your overall development; however, your therapy will not progress if too many sessions are missed.

In the event the client will not be able to attend the scheduled appointment, the client agrees to notify the therapist via phone/email/text. Also, the therapist reserves the right to dismiss client from therapy if the client does not adhere to this cancellation policy. 24 HOUR CANCELLATION NOTICE would be appreciated due to illness or conflicts in schedule. If you need to CANCEL ON THE SAME DAY, please call 678-914-5750 as soon as possible. If you are unable to reach the therapist, please leave a message.

If you do not cancel your appointment and if you do not show up with 20 minutes before or after your scheduled time arrives for the session, it will be considered a "NO SHOW".

Three "NO SHOWS" and/or CANCELED VISITS in 1 month will forfeit your therapy slot. After the third missed visit, we will pass your slot to another client on our waiting list. If you are seen 2 times weekly and have four missed visits, your therapy slot will be passed to another client on our waiting list. If your scheduled visit is inconvenient, please notify your therapist as soon as possible. If the therapist must cancel a visit for personal reasons or vacation purposes, every effort will be made to contact parent via phone, text or email. Every effort will be made to make up therapy session if schedule permits by both client& therapist. Please review Client Handbook for detailed information regarding "make-up sessions."

Client Signature:_____

Date:_____

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 27, 2012 and will remain in effect until we replace it.

We reserve the right to change to change our policy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the Notice and make the new Notice Available upon request.

You may request a copy of our Notice at any time.

1. Milestone Behavioral Health Services, LLC, hereinafter Milestone Behavioral Health Services, LLC is permitted to make use of and to disclose health care information for the purposes of treatment, payment and healthcare operations. The following are examples of use or disclosure for each of the listed purposes:

A. Example of use or disclosure for the purpose of **treatment**: Private health information may be disclosed to gain knowledge about our diagnosis or prognosis to help us treat the client's condition appropriately.

B. Example of use or disclosure for purpose of **payment** Private health information may be disclosed so that we may collect payment from your insurance company or other healthcare coverage.

C. Example of use or disclosure for the purpose of **health care operations**: Milestone Behavioral Health Services, LLC may contact the individual to provide appointment reminders, information about your treatment alternatives or other health related benefit services that may be of interest to the individual.

2. Milestone Behavioral Health Services, LLC is permitted or required to use or disclose protected health information without the individual's written authorization for the following purposes:

A. To maintain a **directory** of individuals.

B. To notify a **family member, a personal representative** of the individual's health or safety, or another person identifiable by the individual to the extent disclosure is directly relevant the individual's care or payment related to the individual's care.

C. Where necessary, to **assist a public or private entity** authorized by law or by its charter, in disaster relief efforts.

D. To **assist a public health authority or other appropriate government authority** authorized by law if reasonable believe that you or your child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may not disclose your health information to the extent necessary to avert a serious threat to your health and safety or the health or safety of others.

E. We may disclose to **military authorities the health information** of **Armed Forces** personnel under certain circumstances. We may disclose to authorize federal official's health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Milestone Behavioral Health Services, LLC will not use your health information for marketing communications without your written consent.

Milestone Behavioral Health Services, LLC may use or disclose your health information to provide you with **appointment reminders** (such as voice mail message, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the cost of copying, mailing, or other cost incurred by us as a result of complying with your request. Request for access to your protected health information must be made in writing.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement except in emergency. You must make your request in writing.

Alternative Communication: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of Department of Health and Human Services if you believe that your privacy right have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made accessing your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to Milestone Behavioral Health Services, LLC communication with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to privacy of your health information.

For more information about HIPPA or to file a complaint:

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

877-696-6775

Authorization for the Release of Medical Records

I,_____ hereby authorize **Milestone Behavioral Health Services, LLC, Inc**. to obtain and release all pertinent medical records, case records, case histories, and/or personal and regular files, for the purpose of financial reimbursement, continuity of care and case management from and to all current and former providers of medical services (to include: Primary care Psychotherapists, Psychologists, etc.) I understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original.

Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent, I fully understand this authorization, and my consent has been made voluntarily.

Acknowledgement of Receipt of Privacy Policy

I, _____hereby acknowledge that I have read/received/downloaded a copy of **Milestone Behavioral Health Services, LLC,** Notice of Privacy Policy Practices with an effective date of February 15, 2013, as it relates to my child _____.

Printed name of Parent/Caregiver/Client:_____

Signature of Parent/Caregiver/Client:_____Date_____

Consent to Bill and Consent to Treat

I,_____ client/parent/guardian), knowing that_____(client/child) has/have a diagnosis requiring Therapy treatment voluntarily consent to such care for the aforementioned client by **Milestone Behavioral Health Services, LLC** as may be beneficial in the professional judgment of the therapist(s) and primary care Psychotherapist. I am aware that no guarantee has been made as to the effect of therapy services.

Initials_____

I hereby authorize **Milestone Behavioral Health Services, LLC** to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to **Milestone Behavioral Health Services, LLC.** I understand that patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider portion of the fees or in full. I agree to pay all fees within 30 days after bill has been mailed and understand that any fees not paid within 30 days will result in a $10 late fee each month that is unpaid. In the event of a returned payment or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees. I understand that I am ultimately responsible for payment of all services received. I understand that I am advised to fully know and understand my insurance benefits prior to receiving therapy services.

Client/Parent/Caregiver (Print):_____
Client/Parent /Caregiver(Signature):_____
Date:_____

Informed Consent for Telemental Health Services

1. TELEMENTAL HEALTH SERVICES

PATIENT NAME: _____

LOCATION OF PATIENT : _____ DATE OF BIRTH:_____

THERAPIST NAME: Akilah Sabir, LPC

Introduction: Telemental Health involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: · Patient medical records · Medical images · Live two-way audio and video · Output data from medical devices and sound and video files Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Expected Benefits: · Improved access to medical care by enabling a patient to remain in his/her Psychotherapist's office (or at a remote site) while the Psychotherapist obtains test results and consults from healthcare practitioners at distant/other sites. · More efficient medical evaluation and management. · Obtaining expertise of a distant specialist. Possible Risks: As with any medical procedure, there are potential risks associated with the use of Telemental Health. These risks include, but may not be limited to: · In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the Psychotherapist; · Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; · In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; · In rare cases, a lack of access to complete medical records may result in adverse or other judgment errors; Informed Consent for Telemental Health. By signing this form, I understand the following: 1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telemental Health, and that no information obtained in the use of Telemental Health which identifies me will be disclosed to researchers or other entities without my consent. 2. I understand that I have the right to withhold or withdraw my consent to the use of Telemental Health in the course of my care at any time, without affecting my right to future care or treatment. 3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Psychotherapist has explained the alternatives to my

satisfaction. 5. I understand that Telemental Health may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state. 6. I understand that it is my duty to inform my Psychotherapist of electronic interactions regarding my care that I may have with other healthcare providers. 7. I understand that I may expect the anticipated benefits from the use of Telemental Health in my care, but that no results can be guaranteed or assured. Patient Consent to The Use of Telemental Health I have read and understand the information provided above regarding Telemental Health, have discussed it with my Psychotherapist as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telemental Health in my medical care. I hereby authorize **Akilah Sabir, LPC** (name of Psychotherapist) to use Telemental Health in the course of my diagnosis and treatment. Signature of Patient (or person authorized to sign for patient): Date: If authorized signer, relationship to patient: Witness: Date: I have been offered a copy of this consent form

Printed name of Parent/Caregiver/Client:_____

Signature of Parent/Caregiver/Client:_____Date_____

INFORMED CONSENT

2. INTERACTION WITH THE LEGAL SYSTEM

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record. If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

_____ _____
Print Parent/Guardia's name (if applicable) Parent/Guardian's signature (if applicable)

_____
Date

_____ _____
Print Client's name (if over the age of 18) Client's signature (if over the age of 18)

_____
Date

RECEIPT OF PARENT HANDBOOK

By signing below indicates receipt of Parent Handbook. Please be sure to obtain a Parent Handbook from your therapist or office staff to review pertinent information and policies & procedures as it relates to services provided by Milestone Behavioral Health Services, LLC.

Print Name_____ Date_____

Parent Signature_____Date_____

TREATMENT PLAN ACKNOWLEGDEMENT FORM

Consumer/Client Name: _____

I, _____, acknowledge that I was an active participant in the development of the treatment plan. I am in agreement with the goals, objectives, and interventions to be implemented to address the current clinical issues detailed during the assessment process.

_____ _____
Consumer/Client Date

_____ _____
Parent/Caretaker/Guardian/Client Date

_____ _____
Assessor/Therapist/Staff Date

DATE:_____/_____/_____

Request for Permission to Provide Services to Client at School

TO: (Principal, School Counselor, or other school official)

_____
(School Name)

RE: _____
(Client/Student Name)

This letter is to notify you that I, _____, give
(Parent/Guardian)

Milestone Behavioral Health Services, LLC (Akilah Sabir, LPC) permission to visit with my son/daughter at school.

If you have any questions or concerns, please feel free to contact me at the following phone number_____.

Thank you for your cooperation.

Respectfully,

_____ _____
Parent/Guardian Signature Relationship to Client

_____ _____
Therapist Signature Therapist name and Title