# Life Integration Therapies

## Patient Financial Policy & New Client Information

Thank you for choosing Life Integration Therapies. We are committed to building a successful relationship with you and your family. Please understand that payment for services is a part of that relationship. Please let us know if you have additional questions after reading this. We look forward to working with you!

**Life Integration Therapies:** 23 E 39th Street, Indianapolis, IN 46205, entrance at door that faces 39th street, office is on the third floor. Please park in parking lot behind building or on the street.

**Payment/Insurance Information:** The first meeting (Intake/Initial Assessment) rate is $150 and after the initial assessment the rate per session, observation, or consultation is $150 per 53+ minutes or $120 for sessions 32-52 minutes. Please inquire about family or group therapy rates. Self pay rates are $120.00 per session.

**Financial Assistance:** We work with every family to make sure that finances do not stand in the way of getting them the help they are looking for. We are willing to set up a discount plan for clients in financial need. To set up a discount plan or for any insurance questions or concerns, please contact Sheila, our Billing Manager, at smoore6638@gmail.com or 317-979-6509.

**Insurance Claims:** We are providers for Blue Cross Blue Shield, United, Cigna, Prohealth plans, Beacon Health (formerly Value Options), and IU Health. If you utilize another insurance plan then we can submit "superbills" electronically to your provider but you will be responsible for payment of each session at the time of the session. Please complete the attached insurance documentation so we can be prepared to discuss your plan.

**Primary Insurance:** We file claims with the client's insurance upon the submission of proof of insurance. If the client cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating client payment at time of service.

**Secondary Insurance:** Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the client and due upon receipt.

**Client Financial Responsibility:** If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, the client is responsible for payment. Co- payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. Any outstanding balance, after insurance has paid, will be charged to your card on file. You may contact Sheila @ 317-979-6509 if you need a receipt. We accept cash, checks, and all major credit cards.

**Missed Appointments:** We understand illness and unexpected events, but we request the courtesy of a 24-hour notice of cancellation. Missed appointments without notice will result in a full charge from the practice.

**Paperwork:** Attached you will find the initial intake paperwork. You can feel free to print these out and bring them with you to our first session. If you forget or do not have access to a printer- don't worry, you can fill them out when you arrive.

**Acknowledge of Receipt:** I have read, understand and agree to Life Integration Therapies financial policy.

Patient / Guarantor Signature:_____ Date:_____

# Life Integration Therapies
## INTAKE FORM

**Counseling Request**

Today's date:_____

**Client Information**

**Client's Name**: _____Birthdate _____

(Last) (First) (Middle Initial)

Gender: M F Age: _____ Soc. Sec. #: _____

Mailing Address: _____

Physical Address:_____

City, State,Zip:_____

Mobile Phone _____May we leave a message at home? Yes No Home

Phone _____May we leave you a message at work? Yes No Work

Phone _____

E-mail _____

**Emergency contact information**

Contact name: _____ Relationship: _____

Phone:_____

Contact name: _____ Relationship: _____

Phone:_____

# Life Integration Therapies

## Payment/Insurance Information

Preferred payment method for each session: ___ cash/check ___ credit card ____other:

****We request a credit card number to keep on file for convenience of co-pays, payment or missed appointments.**

_____Please initial if you approve of Life Integration Therapies charging this card for co-pays or session fees.

Credit card #_____

Name at it appears on card_____

Expiration:_____ CVV code:_____

Billing Address & zipcode _____

_____

**If you plan to utilize insurance and/or you would like us to submit information to your insurance please fill out the Insurance Verification Form at the end of this packet.**

****Please supply us with a photocopy of the back and front of your insurance card or we can copy your card in the office in order to submit to your insurance. All insurance information will be submitted electronically to your insurance company within one week of your session appointment.**

Would you like us to submit these claims to insurance? _____ Yes _____ No If yes, please fill out the attached insurance form.

### Goals for therapy

Can you please list a few things you would like to accomplish or address in therapy?

1._____

2._____

3._____

# Life Integration Therapies

## Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to lay an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop treatment with this therapist at any time. The only things I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)

_____(initial) I understand that the charges for the intake (first meeting) and the additional agreed upon minutes of therapy, observation, and consultation is due at time of session unless arrangements have been made with Life Integration Therapies regarding insurance. Cash, check and credit cards are accepted.

_____ (initial) **I understand that if I keep a credit card on file that this card will be charged for co-pays/ session fees (if checked as the preferred payment method), or missed appointments that have not been canceled 24 hours prior.**

_____(initial) I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment. I know that my credit card on file may be charged if therapist is not informed otherwise.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment.

My signature below shows that I understand and agree with all of these statements.

Client's Signature: _____ Date_____

Printed Name:_____

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist:_____ Date_____

____ copy accepted by client _____ copy kept by therapist

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

# Life Integration Therapies

## Insurance Verification Sheet

****Please supply us with a photocopy of the back and front of your insurance card or we can copy your card in the office in order to submit to your insurance.**

Please call your insurance company prior to your initial appointment. On the back of your insurance card (typically) locate the telephone number provided for Mental Health/Substance Abuse and/or Behavioral Health.

Policy Holder's Name: DOB of policy holder:

Address of policy holder (if different):

Insured's ID:
Group ID:

Insurance Company Name:

Effective Date:

Telephone Number for Benefits:

****Copy of insurance card front and back is required.** ***Copy received by clinician ___ yes ___ no***
**Please make sure to request outpatient mental health benefits when calling. Ask and complete the following:**

1. Does your insurance cover counseling by a Licensed Professional Counselor? **Y / N**

2. Is Kay Whithead, tax ID# 262091177, an in network provider? **Y / N** *If not, ask if your plan pays for out-of-network benefits.* **Y / N**

3. Is there a deductible? **Y / N** *If so, have you met the deductible?* **Y / N**

4. What percentage of the deductible has been met? _____

5. What is your co-pay or percentage you are expected to pay? _____

6. Is there a limit on visits per year? **Y / N** *If so, how many visits per year are issued?* _____ *How many have you used?* _____

7. Do the service limits run per traditional calendar year? **Y / N** *If not, how does the year run?* _____

8. If you have a co-pay or you still need to meet your deductible, would you prefer to keep a *credit card on file to pay for these amounts __ yes__no
   or do you prefer to pay these amounts at each session with check or cash __yes__no

   *All major credit cards, HSA, flex-savings account cards are accepted.
   Please feel free to call us before your session or during your first session to discuss any questions or concerns about insurance and payment.

# Life Integration Therapies

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.**
**PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment**. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

**For Payment**. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization**. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

**Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

**Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.** PHI may only be disclosed after a special approval process.

**Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

# Life Integration Therapies

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to me at Life Integration Therapies, 23 E 39th Street, Indianapolis, IN 46250 or call 317-300-5196.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the me if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

**COMPLAINTS**

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me at Life Integration Therapies, 23 E 39th Street, Indianapolis, IN 46250 or with the Indiana Office of Inspector General at 315 W Ohio Street #194, Indianapolis, IN 46202 or by calling 317-232-3850. **We will not retaliate against you for filing a complaint.**

**The effective date of this Notice is 2017.**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Life Integration Therapies Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Life Integration Therapies at 317-300-5196 or Sheila Moore @ 317-979-6509.

**Signature of Patient/Client:_____Date_____**

❑ **Patient/Client Refuses to Acknowledge Receipt**:

**Signature of Staff Member:_____ Date_____**