Compass Point

Group Registration

FULL LEGAL NAME _____ PREFERRED NAME _____

BIRTH DATE _____ GENDER _____ SS# _____

ADDRESS _____
STREET/APT CITY STATE ZIP CODE

HOME PHONE_____ CELL PHONE_____ EMAIL _____

*is it okay to call or leave a message at home? ☐ Yes ☐ No *is it okay to send email? ☐ Yes ☐ No

*is it okay to call or leave a message on your cell? ☐ Yes ☐ No *is it okay to send text message? ☐ Yes ☐ No

EMPLOYER _____ WORK PHONE _____ *is it okay to call at work? ☐ Yes ☐ No

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____ DOB _____
FIRST MI LAST

_____
STREET/APT CITY STATE ZIP CODE

SS#_____ NAME OF EMPLOYER_____ EFFECTIVE DATE _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICE PHONE (Located on back side of card) _____

Does the client have any additional insurance? ☐ NO ☐ YES, please complete the following:

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____ DOB _____
FIRST MI LAST

_____
STREET/APT CITY STATE ZIP CODE

SS# _____ NAME OF EMPLOYER_____ EFFECTIVE DATE _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICE PHONE (Located on back side of card) _____

If you have two insurance carriers you will need to notify both plans so they are able to coordinate benefits. Without this your claims may be held.

ADDITIONAL INFORMATION

How did you learn about us? (If online, did you use a search engine?) _____

Name and phone number of person to be contacted in case of emergency:

Name_____ Phone number _____ Relationship _____

Name of Primary Care Physician _____ Phone_____ Date of Last Visit _____

Name of Psychiatrist_____Phone_____ Date of Last Visit _____

CLIENT NAME _____ DATE _____

CONSENT TO TREATMENT

The undersigned, client/client's legal guardian, voluntarily consent to outpatient treatment for mental health, co-occurring, and/or substance use and authorize Compass Point Counseling Services (CPCS) to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include individual or group counseling/therapy, diagnostic assessment, and psychological testing.

MEDICARE PAYMENT

I, the undersigned, certify that any information given by me in applying for payment under Title XVII of the Social Security Act is complete, accurate, and current. As a Medicare Beneficiary, I have the right to receive Medicare covered services. I acknowledge that I have the right to be involved in any decisions about my treatment and services and who will pay for them.

WAIVER OF LIABILITY FOR NON-APPROVED SERVICES

Ohio law requires CPCS to inform the undersigned that if your insurance company did not give prior approval for therapy services and you choose to have services provided, you would be required to pay for the services. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for the payment of all services incurred. These services include both formal and informal (letters, appearances in court, reports, and extended phone calls.)

EXPLANATION OF SERVICES

- We share this suite with our colleagues and we provide ongoing supervision for each other.
- We provide individual, family and group counseling and are happy to discuss these options with you.
- If a crisis occurs when we are not in the office you may call our main number (513) 939-0300 and you will be directed as to how we may be reached.
- We make the assumption that you can change and grow, and that some of this change can occur within a relatively short period of time. We strive to do brief and effective treatment.
- Our fee is $120 per hour for a regular 45-55 minute session and $150 for the initial session for an LPCC/LISW, $80 per hour for a regular 45-55 minute session and $120 for the initial session for an LSW/LPC
- **Payment is expected at the time of service**. You are responsible for the charges. If you are paying through your insurance, you are responsible for your co-pay or deductible at time of service and for any amount left unpaid by your insurance.
- Additional fees will be charged for letters, appearances in court, reports, no show or late cancellation charges and extended phone calls. These things may not be covered by insurance. Your therapist will discuss any additional fee with you before it is charged.
- We view the therapeutic relationship as a partnership that is principally dedicated to your growth and to finding solutions. Part of our job is to remind you of your own strengths and abilities while you go about the business of creating more of the type of life that you want.
- As with nearly any type of treatment, there is the chance that it may not be helpful. The "fit" between client and therapist is important to good treatment outcome. In the beginning of treatment, you may feel worse before you feel better. Therefore, we want to hear from you throughout our work together about how we are doing – so that we can make any needed adjustments to help you more effectively.
- Information discussed within the therapy setting is held confidential and will not be shared without written permission except under limited situations which under reasonable circumstances would be discussed with you before disclosure is made. These situations include revelations of *unreported* child or elder abuse, imminent suicide or harm to others, or reports of exploitation by a therapist.
- Our practice is only to release clinical notes generated from your contact with us. We do not release raw materials or records obtained from third parties

LATE CANCELLATIONS, MISSED APPOINTMENTS

I understand that I am required to provide at least 24 hours notice if I am unable to keep a scheduled appointment. In the event that I do not provide 24 hours advance notice, I acknowledge that CPCS has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come to set appointment at my (or the client's) scheduled appointment time, I understand that CPCS will charge me $50.00 for the scheduled appointment. I agree to pay CPCS $50.00 for late cancellation or missed appointment charges incurred, before or at my next appointment.

RETURNED CHECK FEE: CPCS charges a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay CPCS the returned check fee of up to $50.00.

DELINQUENT ACCOUNT: I understand that CPCS may turn my account over to a collection agency if I do not pay on a timely basis. CPCS has a separate collection policy, which will be provided to me if I ask for it. I also understand that if my account is sent to a collection agency a 35% surcharge will be applied to the balance by the collection agency.

ANCILLARY SERVICES

These are any extra services are not typically covered by your insurance.

- Letter or Report writing- $150 per hour prorated. Payment is required prior to writing letter.
- Telephonic Services- $40 per 15 minute increments.
- Court Related Charges-Your therapist will not go to court voluntarily. Please understand that when your therapist goes to court other clients have to have their appointments cancelled for the week. The Magistrate or Judge hearing your case must subpoena the therapist.
  - The office must receive a retainer cost of $500.00 prior to therapist blocking out their schedule to appear in court.
  - As a rule we do not testify in custody situations. Per our ethics board we cannot, and will not, make recommendations related to custody, guardianship or parenting
  - $150 per hour from portal to portal
  - Any additional charges over that will be billed to you following the hearing.
  - In the event the therapist believes that testifying in court would be detrimental to the therapy process the therapist may hire their own attorney to have the subpoena overruled. Any legal fees resulting from this action will be charged to the client that has requested the therapist's appearance.
- Testing- Prices for testing vary and are available upon request.
- Medical Record request: Prices are based on Ohio regulations and are subject to change
  - $2.00 per page for the first 10 pages, then $0.50 per page 11 – 50, $0.20 per page 51 & higher
  - Actual cost of postage to send records

CLIENT NAME _____ DATE _____

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, including Medicare, if the client is a Medicare beneficiary, be made on the client's behalf to CPCS for any services provided to the client. **It is my responsibility to notify CPCS of any changes in my health care coverage.** In some cases exact insurance benefits cannot be determined by CPCS and/or my mental health care insurer if the submitted claims or any part of them are denied for payment. The undersigned acknowledges that by signing this form I am accepting financial responsibility as explained above for all payment for services received. Compass Point Counseling Services appreciates the trust you have in choosing us to provide mental health care services to you, or a client of the office for whom you have responsibility. Our client-and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies. I acknowledge that I am financially responsible for all charges associated with mental health services provided by CPCS to me (or the client named below). **I understand that payment for services is due at the time services are rendered** unless special arrangements are made in advance.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance and/or EAP benefits. I also hereby authorize payment of insurance and/or EAP benefits otherwise payable to me directly to the therapist/CPCS.

AUTOMATIC BILLING OR PAY AT TIME OF SERVICE

Accounts with Compass Point Counseling Services may enroll to automatically have account balances billed to your credit card. If you wish to take advantage of this service please complete the lines below. By providing your billing information you acknowledge consent for us to automatically process charges to the credit card you have provided below.

We will **only** charge services rendered to your card. Your card will **NOT** be charged in the event that you are assessed a charge for canceling within or at 24 hours of an appointment or for not keeping a scheduled appointment. However, we do ask that you pay these charges in a timely manner.

I understand that I have given Compass Point Counseling Services permission to charge my credit card. I also understand that if my insurance applies any amount to my deductible or denies payment, the full amount of the visit will be billed to my credit card.

EMAIL REMINDERS

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your clinician name. These emails are not encrypted. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

By providing your email you acknowledge consent for us to send you appointment reminders to the email you have provided below.

Part of our mission here at CPCS is to provide excellent training to upcoming professionals. All of our professionals in training work under the close supervision of qualified supervisors. We sometimes use audio/video recording for training purposes. Those present are made aware and always have the option to refuse. These recordings are used strictly for training purposes. Without exception, the staff at CPCS is trained in and expected to adhere to privacy practices. (Please check the appropriate box)

☐ I agree and consent to participate in supervised training sessions **with audio/video recordings** upon my permission.

☐ I agree and consent to participate in supervised training sessions **without audio/video recordings.**

☐ **I do not consent** to participate in supervised training sessions.

OTHER INFORMATION

I, the undersigned, agree to abide by CPCS's policies and procedures and recognize that my compliance will minimize the danger of accidents or injury to myself, other Clients and employees of CPCS. I, the undersigned, acknowledge responsibility for myself and my actions and liability arising or resulting from my actions/omissions while I am being treated at CPCS. I, the undersigned, acknowledge that CPCS is not responsible to me or my property for the actions/omissions or any liability arising from the actions/omissions of any other clients at CPCS.

☐ I read and understood the Client Responsibility agreement.

- ☐ Please bill all of my appointments to the insurance or EAP that I have provided you.
- ☐ I prefer to be billed for all appointments at the agreed upon private pay rate, whether or not I have insurance coverage.

☐ I read and understand the supervised training consent

☐ I read and understand the email reminders. Email: _____

☐ I read and understand the Credit Card Automatic Billing ***OR*** ☐ I will pay the expected amount at the time of service

Client Name:_____ Cardholder Name:_____

Credit Card Number:_____ Expiration Date:_____ Security code:_____

I, the undersigned, understand that at any time I may elect to participate in other services or refuse any services, treatment or therapy upon full explanation of the expected consequences of such refusal

I have received a copy of the NOTICE OF PRIVACY PRACTICES (HIPPA) which includes the client's rights and grievance policy.

NAME	RELATIONSHIP TO CLIENT	DATE	SIGNATURE