Telehealth Policy

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:

- Client health records
- Live two-way audio and video
- Output data from health devices and sound and video files

This form describes Comprehensive Counseling's Telehealth treatment and payment policies and includes:

If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

- I understand, and agree that:
  - I will not be in the same location or room as my medical provider.
  - My Comprehensive Counseling provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
  - The laws of the state in which I am located will apply to my receipt of telehealth services.
  - Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my Patient First provider's office; (ii) more efficient medical evaluation and management; and (iii) Obtaining expertise of a distant specialist.
  - Potential risks of telehealth include: (i) In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s); (ii) Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment; (iii) In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
- By signing this form, I agree to:
  - Dress appropriately (i.e. fully clothed in proper attire)
  - Hold sessions in an appropriate place (i.e., not in bathroom, not laying down in a bed)
  - Not have anyone else present without first discussing with my therapist
  - Not record the audio or video session

I may discuss these risks and benefits with my Patient First provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the

telehealth session at any time without affecting my right to present or future treatment by Comprehensive Counseling.

In the event that my insurance does not cover telemedicine, I will be charged the clinician's or physician's self-pay rate.

Signature of Client (or person authorized to sign for client):
Date:

CLINICAL INTAKE FORMS

Patient Information:		
First Name:	Last Name:	D.O.B.

CONSENT FOR TREATMENT

General Consent for Treatment:	
I consent to treatment with Comprehensive Counseling LCSW's PLLC. I recognize this agency provides therapeutic services to families, individuals and couples. I understand that Comprehensive Counseling LCSW's PLLC does not provide emergency services. I understand that a variety of topics may be covered throughout the course of treatment. I understand that Comprehensive Counseling LCSW's PLLC specializes in working with clients on a variety of topics and issues to nurture change by identifying and developing insight on patterns and relational dynamics. I understand that Comprehensive Counseling LCSW's PLLC strives to create a safe environment where all clients feel comfortable and heard by the therapist and their family member(s). I hereby give my consent for evaluation/treatment to be administered to the person listed above by employees or independent contractors of Comprehensive Counseling LCSW's PLLC, without my being in attendance. I understand that my therapist, health plan representative, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/ or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.	
Printed Name of Patient or Patient's Parent / Legal Guardian	Signature of Patient or Patient's Parent / Legal Guardian
Relationship to Client	Date Signed

INSURANCE / PAYMENT INFORMATION

Please read and sign below to verify that you understand Comprehensive Counseling's policies.

GENERAL INFO
I understand that payment for treatment is due at the time of service unless other arrangements are made. Payments can be made in the form of cash, check or credit card. Copayments are due prior to each session and can be made to the receptionist, or to my therapist if no receptionist is present. I am responsible for payment of my account within the limits of our credit policy regardless of insurance coverage. I authorize Comprehensive Counseling LCSW's PLLC to release all information necessary to secure payment. I assign all medical benefits to which I am entitled to Comprehensive Counseling LCSW's PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

INSURANCE COVERAGE
I understand that it is my responsibility to verify current coverage with my insurance provider. Any changes to my insurance policy or coverage must be reported to Comprehensive Counseling LCSW's PLLC before services are rendered.
My insurance company will be billed for all services provided to me; however, if for any reason my insurance company does not pay, I am responsible for paying the service I received at the self-pay rates of **$100 for the initial consultation and $80 for all other follow-up sessions.**
It is my responsibility to know which services my insurance company covers. I have been advised that some or all of the services provided may be "non-covered" services and may not be considered reasonable and necessary under the Medicaid program and/or my medical insurance.
I am responsible to pay my co-payment and deductible (if applicable) **before** my appointment. **Lack of payment for 3 sessions or more will result in suspension of services, until balance is paid.** It is my responsibility to contact my insurance company if I need an explanation of benefits.

CHARGES FOR MINOR CHILDREN
I understand that if the person responsible for the balance of the account is not present, the parent, legal guardian, or person present will be assumed to be the responsible party, regardless of court orders or any other documentation placing responsibility of payment fees upon one parent or the other.

CHARGES FOR MISSED APPOINTMENTS
I understand that there will be no charge if I call and cancel at least 24 hours prior to my scheduled appointment; however **if I do not come in for a scheduled appointment and no phone contact has been made at least 24 hours prior to the time of the appointment, I will incur a charge of $80.00. Lack of payment for 3 sessions or more will result in suspension of services, until balance is paid.**

Signature

Printed Name of Patient or Patient's Parent / Legal Guardian	Signature of Patient or Patient's Parent / Legal Guardian
Relationship to Patient	Date Signed

Credit Card on File Policy

Thank you for choosing Comprehensive Counseling for your behavioral health needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, Comprehensive Counseling will require all patients keep an active credit card on file with us.

By signing this form, I acknowledge and agree that:

1. It is my responsibility to determine whether Comprehensive Counseling's services are covered by my insurer. I will pay the cost of any service that is not covered by my health plan for any reason or are covered but applied to a deductible.
2. By providing my credit card or eCheck information and receiving telehealth services, I (i) authorize Comprehensive Counseling to charge my credit card for any and all unpaid amounts that Comprehensive Counseling or my insurer determines are my responsibility, and (ii) agree to pay all amounts charged pursuant to this consent and authorization in accordance with the issuing bank cardholder agreement. I agree that Comprehensive Counseling may charge my credit card for such amounts at the end of my telehealth visit or at a later date.
3. I will pay at time of service any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance, outstanding balances and delinquent accounts.
4. I will be billed for all unpaid balances deemed by Comprehensive Counseling or my insurer to be my responsibility and agree to pay such amounts in full, including missed session fees
5. I assign to Comprehensive Counseling all health care benefits to which I am entitled under any insurance policy or benefit plan and authorize payment of benefits directly to Comprehensive Counseling.
6. If I have health care benefits, Comprehensive Counseling will submit a claim to my insurer and allow 60 days for a response. If my insurer does not respond within 60 days, Comprehensive Counseling will assume that the visit is not covered and will, to the extent permitted by law, bill me for the visit charges
7. If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give Comprehensive Counseling a new, valid credit card which I will allow them to key-in over the phone. Even though Comprehensive Counseling is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card which I presented in person.

8. If I disagree with the patient responsibility balance owed, it is my responsibility to contact my insurance carrier immediately.
9. I understand that this form is valid until I cancel this authorization through written notice to Comprehensive Counseling.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on File.

Card on File Info	
Name on card:	Expiration Month:
Card Number:	CVV:

Signature of Client (or person authorized to sign for client):
Date:

ACKNOWLEDGEMENT OF RECEIPT OF POLICIES & PROCEDURES

<table>
<tr><td colspan="3">Please visit http://www.CCLCSW.com/patient-information/ for policies and procedures</td></tr>
<tr><td>First Name:</td><td>Last Name:</td><td>D.O.B</td></tr>
<tr><td colspan="3">I, ___________, affirm that I have received, read, understand and agree to everything written in the policies and documents (listed below) given to me by Comprehensive Counseling LCSW's PLLC. By checking the box and by the presence of my signature, I affirm that I have received copies of these documents and have asked questions when clarity was needed. These policies have been explained to me in my own language, when applicable.</td></tr>
<tr><td colspan="3">Notice of Privacy Practices, Clients Rights & Responsibilities, Grievance Policy & Procedure, Behavior Support & Management, Mandatory Report of Suspected Abuse</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2">Signature of Patient</td><td>Date Signed</td></tr>
</table>

Communication Policy

I, ___________, hereby consent to have my counselor, psychiatrist, and other staff at Comprehensive Counseling LCSWs, communicate with me by e-mail, voice or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that e-mail, voice and SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that e-mail, voice and SMS messaging regarding my medical care might be intercepted and read by a third party.

I understand that e-mail, voice or SMS messaging is not to be used for emergencies or crises. E-mail communication cannot take the place of clinical appointments and will not be used for extended clinical discussions.

Signature of Client (or person authorized to sign for client):
Date: