A

Breakthrough Counseling

Welcome to the Breakthrough group.

Thank you for placing your confidence in us. Our goal is for you to feel welcome each and every visit. Please let us know if you have any questions.

Linda Russell, MHR, LPC
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Ashley Wyckoff, LPC, NBCC
Monica Hamer, LCSW

2452 W New Orleans St
Broken Arrow, OK 74011
918-286-3278
Breakthrough-Counseling.com

Be sure to talk with your therapist if there are any questions about your treatment.

The front desk is ready to help you with any questions about your scheduled appointments or financial issues.

You will complete some necessary paperwork on your initial and 2nd visits. One of those forms includes a credit card guarantee. Once this form is completed with your number, it is scanned into an electronic HIPPA compliant platform and the paper with the number is shredded. Please carefully read the financial and missed appointment policies. This is a business and we respect the time and efforts of all the therapists. **A 24 hour cancellation notice is required if you are unable to make your scheduled appointment. If a 24 hour notice is not given, you will be assessed a $100.00 charge for a late cancellation unless you are able to reschedule during the same week.** This policy insures that your therapist has the opportunity to be paid for their time. Our financial and missed appointment policies are in place to keep the best therapists available to serve you.

We want you to achieve your healthcare goals. As with all healthcare treatment, your best opportunity for positive outcomes of treatment is to keep your schedule of care and complete any homework assignments.

Again, thank you for choosing the Breakthrough group. We believe you are on the road to the breakthrough you seek and desire.

Ded $______ Met $_____

Co-Pay $_______Co-Ins %______ Allowed $_____

Pt. Owes $__________

DX______.____

Client Contact Record

Office Use Only

Patient Name________________________________**D.O.B.**______________________**Age**____________

Address______________________________________**City**__________________**State**______**Zip**________

Home Phone ___________________**Work Phone** ____________________ **Cell Phone**__________________

Social Security Number ________________________**EAP/Insurance Co.**_____________________________

E-Mail Address____**Do you check daily?** _______

If Minor Client - Parent(s) Name______________________________ **Spouse's Name**__________________

May we contact you by phone at the above number(s)? ____**Yes** ____**No**
___ **Home Only** ____**Office Only** ____**Cell Only**

Stop – The next section is for office use only.

Auths./ Session #	Date	Code/ Procedure	Persons Attending or Contacts	Initials Clinician/Staff

CPT CODES:

90791 – Psy. Eval./Intake
90846 – Family w/o Pt
90839- Crisis(60 min)
90834/32 – Ind./ ½ Session
90853 – Group
90808 – 75-80 min. session
90830 – Testing w/Report
90847 – Family, Marital, Couple
90889 – Clinical Report

OTHER CODES: **CX** – canceled appt. **CAC** – Canceled appointment charged for **NS** – broken appt/no show **CO** - consult

B

Breakthrough Counseling, LLC
Patient Information

Referred by: ______________________________ Date: ____________________

Name: First __________________ Middle _______________ Last ______________________ Nickname ______________

Address: ________________________________

City: _____________________ Zip: ___________

Home Phone: ____________________________

Work Phone: ____________________________

Fax: ____________________________________

SS Number: ______________________________

Date of Birth: ____________________________

Male ________ Female __________

Employer: _________________________________

Marital Status: _____________________________

Student Status: _____________________________

Emergency Contact: __________________________

Relationship: ______________________________

Phone: ____________________________________

Custodial, Guardian Parent, or Other Billable Party Information

Name: __________________________________

Address: ________________________________

City: ___________________________________

State: ______________ Zip: ______________

Send bills to the name/address? Yes ____ No ____

Home Phone: ______________________________

Work Phone: ______________________________

Cell: ____________________________________

Fax: _____________________________________

<u>Primary</u> Insurance Information

Policy Holder Name: ___________________________

Social Security Number: ________________________

Insured's date of Birth: ________________________

Patient Relationship to Insured: __________________

Insured's ID: _____________________________

<u>Primary</u> Insurance Co:___________________________

Employer Providing Plan: ____________________

Group Number: ___________________________

Please notify the receptionist of you have secondary insurance coverage.

This '**PHYSICIAN RELEASE**' permits your therapist to inform your Primary Care Physician (PCP) of your therapy.
May we release your therapy information to your Primary Care Physician? Yes ______ No ______

Please Notify: Dr. ________________________________ Tel: ( ) ______-_________ Fax: ( ) _____-__________

Address: ____ State: __________ Zip Code: ________________

Release of Medical Information

I authorize payment of insurance benefits to Breakthrough Counseling, LLC. I understand that I am financially responsible for any charges not covered by insurance or third party payer.
I authorize the release of any medical information necessary to process this claim. Oklahoma State Law (O.S. 63 Sec. 1-5022) requires the following statement: The information may include records which may indicate the presence of a communicable or venerable disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immune Deficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS).

Signature of Responsible Party: ______________________________________ Date: ____________________

Breakthrough Counseling Informed Consent

CONFIDENTIALITY: Everything you say is these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law.

__________ **Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that the you present a danger to others. Disclosure may also be required by the courts. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. __________ **Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet. __________ **Initial**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier.

__________ **Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. __________ **Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call us at (918) 286-3278. If we do not answer, we will return your call as soon as possible. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room. __________ **Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral,

cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe drugs.

__________ **Initial**

TREATMENT PLANS: On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. __________ **Initial**

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that a case, I will give you a number of referrals whom you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. And upon your request, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. __________ **Initial**

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are either unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

__________ **Initial**

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. __________ **Initial**

I have read the above policies. I understand them and agree to comply with them:

Client's Signature ______________________________________ **Date** ______________

Therapist's Signature ____________________________________ **Date** _____________

Patient History

Name____________________ DOB__________ Today's Date __________

List symptoms you are experiencing, when they first started and how long they have lasted:

Please provide your Mental Health History, previous treatment, with whom and for how long?

Family Members with Mental Health Concerns: ____________________

Education, highest level achieved: ____________________

Current Job Status: ____________________How long?__________

Medical history, current health: ____________________

Medications, Dose: ____________________

Herbals, Dose: ____________________

Allergies: ____________________

Alcohol Use (amount, frequency):____________________

Cigarettes, cigar, other tobacco use (amount, frequency): ____________________

Recreational Drug Use (What, Amount, Frequency, Age of initial use): ____________________

Have you missed work due to drug use or drinking? _____ Have others expressed concern about your drug use or drinking?_____

Please List your Hobbies, Interests and Recreational activities:

Spiritual Preferences:

What do you hope to accomplish from your therapy?

Patient'sSignature:____________________Date:__________

NO SYMPTOMS/STRESS | ____________________ | EXTREME SYMPTOMS/STRESS

Please place and "X" on the line above to indicate level of problem

Therapist's Signature: ____________________Date:__________

Breakthrough Counseling

FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Welcome to Breakthrough Counseling. Please read over our financial and missed appointment policy. If you have questions feel free to ask the Breakthrough Counseling staff.

FINANCIAL POLICY

Fees. Counseling sessions are 45 minutes long. The fee for a 45 minute session, either face-to-face or by phone ranges from $125-$175 depending on your provider. We also ask you to place a credit card on file for future billing. A $25 fee will be charged for any returned checks.

Charges. Occasionally there are extra charges or other altered charges but in your case the fee for the 45 minute sessions will be _$150.00.

Insurance Patients. If you have health insurance Breakthrough Counseling is happy to call your insurance company and verify your insurance benefits. We will also file your insurance for you. If your insurance covers a portion of your therapy we will be happy to wait for 90 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Self-Pay Patients. Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. Breakthrough Counseling accepts cash, checks, and major credit cards.

Payment in Advance. If your therapist suggests more than ten visits, you may pay for them in advance and receive a discount of .Payment for multiple visits must be made by the third visit.

MISSED APPOINTMENT POLICY
Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged a $100 fee unless you are able to reschedule during the same week. Appointments missed because of inclement weather will not be charged. Your fee will be applied to your credit card on file. All charges will appear as **Manhattan Management**. I understand it is my responsibility to maintain an **active and up to date credit card** on file to avoid any additional charges.

I have read and agree to the above conditions.

Name ______________________________ **Date** __________________

Breakthrough Counseling
CREDIT CARD GUARANTEE
FOR PERSONAL BALANCES

[ ] UNINSURED PATIENTS

Patients who are uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

[ ] INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for the payment. Please remember, however, that you are ultimately responsible for payment. On day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be refunded to you.

I agree to the above terms and authorize you to charge any balance not paid by the end of each week to the credit card below util the account is paid in full. I understand it is my responsibility to maintain an active and up to date credit card on file to avoid any additional charges. All charges will appear as Manhattan Management.

____ ________________

SIGNATURE DATE

CREDIT CARD: AMEX VISA MC DISCOVER

CARDHOLDER'S NAME: ____

BILLING ADDRESS: ____

____

CARD#____________________________________ EXP. DATE: ______________

THREE DIGIT CODE ON BACK: ________

Breakthrough Counseling
2452 W New Orleans St- Broken Arrow, OK 74011

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.
You may refuse to sign this acknowledgment, if you wish.

I Acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please Print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The Patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the patient ..
- Other (Please provide specific details) ______________________________________
____

______________________________________ ______________________
Employee Signature Date