Acknowledgement of Clinical Practice Information

I acknowledge the receipt of Counseling Connections Informed Consent Policy, Social Media Policy, Office Policy and Agreement for Psychotherapy Services. I agree to the terms of these policies and agree to comply with these policies. All policies will be available on the Counseling Connection website and I may request a copy at any time.

I understand the licenses held by the providers of Counseling Connections. In particular, Omega J. Galliano, M.S., is a Licensed Alcohol and Drug Counselor (619-L) and Marriage and Family Therapist (0551) in the State of Nevada and in the State of Iowa (086515) as well as a Licensed Psychologist (LP0146) in the State of Minnesota.

I attest to the receipt of the HIPAA Notice of Privacy Practices for my review. I understand that the HIPAA form will be available on the Counseling Connection website and I may request a copy at any time.

_____ _____
Signature (Client 1) Date

_____ _____
Signature (Client 2) Date

_____ _____
Signature (Client 3) Date

_____ _____
Signature (Client 4) Date

Counseling Connections

Patient Information

Please fill out the following information form completely and sign.

****

Patient:_____**Date:**_____

Address:_____

City:_____**State:**_____**Zip:**_____

Date of Birth:_____/_____/_____**Sex: M ☐ F ☐ Ethnicity:**_____

Home Telephone:(____)_____**Work Telephone:(____)**_____

SS# _____ **Email:** _____

Employer/School:_____

Martial Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐

Emergency Contact _____ **Telephone:**_____

****

Health Insurance Information

Primary Insurance:_____

Name of Insurance Holder:_____

Insurance ID Number:_____**Group Number:**_____

Present insurance card so copy can be made for file.

****

Clinical Information

Relevant Medical Conditions (history, current condition, changes in condition):

_____

Medications (dosage, dates of initial prescription, name of prescriber):

_____

Allergies/adverse reactions to treatment:

_____

Primary Care Physician:_____

Address:_____**City:**_____

State:_____**Zip:**_____ **Telephone: (____)**_____

Reasons for seeking counseling today (include prior history of counseling for mental health, alcohol or other drub problems):

_____

_____

Consent Statement

I hereby authorize Counseling Connections to release to my insurance company, or its representatives, any information including the diagnosis and the records of any treatment provided to me during the course of treatment.

I authorize and request that my insurance company pay directly to Counseling Connections the amount due for services. I agree that I will be responsible for all co-pays, deductibles, and non-covered services. I further accept responsibility for verifying my insurance coverage. I understand and agree to a charge of the standard hourly rate should I miss an appointment or fail to cancel prior to 24 hours of the appointment time.

I understand that, in the event of non-payment, for any reason on my part, that counseling Connections may turn the balance over to a collection agency.

Signature _____***Date***_____

Clinician's Name & Degree: Omega J. Galliano, MS

Clinician's Signature Omega J. Galliano ***Date***_____

Payment Expectations

In-Office Sessions:

All payment or co-payment is due at the time of the session unless other arrangements have been made. Private pay, insurance, or employee assistance programs are common payment options. We will file your insurance claim if we are a contracted provider, but you are responsible for contacting your insurance company for pre-authorization prior to your first session.

Further, you are responsible for deductibles, co-insurance, and co-payments and to familiarize yourself with your insurance benefits. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

Telemental Health Sessions:

Payments via credit or debit card can be processed through **Square** and are due prior to beginning treatment. At this time, many insurance companies do not cover Telemental health, however more are doing so. Please contact your insurance company or employee assistance program for information regarding your particular policy.

By signing this, I agree to, and understand, the payment terms as described above:

_____ _____

Client Signature Date

Counseling Connections
Release of Information Authorization

I, _____, _____
(Print Name) (Social Security Number)

Hereby give permission to: _____ to disclose the

Following information to: _____ in connection with my case.

□ Diagnostic Assessment
□ Treatment Plan
□ Progress Notes
□ Substance Abuse Evaluation
□ Treatment Recommendations
□ Expected length of treatment
□ Entire Record
□ Other: _____

The purpose for such disclosure is:

□ To provide continuity of care
□ To permit processing of a benefit claim
□ To enable my employer to make an employment status determination
□ Other _____

I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If I do not revoke it, this consent will expire one year after the case is closed.

_____ _____
(Signature) (Signature of parent/guardian)

_____ _____
(Date) (Witness)

I understand that my records are protected under State confidentiality statutes and may be protected under Federal regulations (42 CFR, Part II) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Authorization will remain in effect as agreed to above. Upon revocation of consent, further release of information shall cease immediately. File copy is equivalent to the original.