TREE of LIFE
COUNSELING

Patient Notice and Compliance Practices

Patient Name_____

Any questions or concerns regarding care provided at Tree of Life Counseling, PLLC may be addressed by contacting:

1821 Lendew Street, Greensboro, NC 27408
Ph. 336.288.9190 Fax 336.450.4318
admin@tlc-counseling.com

_____ I have read and reviewed TLC's HIPAA & Notice of Rights document located on TLC's website www.tlc-counseling.com http://tlc-counseling.com/wp-content/themes/tlc/files/TLC%20Patient%20Handbook.pdf

Demographic/Insurance Information

Client Information

Legal Name	**Preferred Name**	**SSN**	
Street Address	**City**	**State**	**Zip**
Cell Ph	**Home Ph**		
Date of Birth	**Legal Gender**	**Employment Status:**	**Marital Status**
Race	**Identified Gender**	**Email Address**	

Financial Responsible Party

Is client responsible party/guarantor? ☐ **Yes** (Skip this section) ☐ **No** (Complete section below)

Name	**Address**	**Email**	**Relationship to Client**
City/State/Zip	**Date of Birth**	**SSN**	
Cell Ph	**Home Ph**		

Insurance Information

Primary Insurance Company	**Policy #**	**Group #**
Client's Relationship to Insured	**Name of Subscriber**	
Phone Number on BACK of Ins Card for Mental Health:	**Employer**	

Emergency Contact

Name	**Relationship to Client**	
Cell Ph	**Work Ph**	**Home Ph**

PCP Info

Primary Care Physician's Name/Practice	**Physician's Ph**
Physician's Address ****If no PCP, which is your preferred emergency room***	

Medical Information

List Medical Problems/Conditions	**List All Current Medications**

PLEASE BRIEFLY DESCRIBE THE NATURE OF THE PROBLEM AND THE KIND OF HELP YOU ARE LOOKING FOR:

HOW DID YOU HEAR OF US:	WHICH THERAPIST ARE YOU REQUESTING:

Have you ever been to TLC previously? If so, who was your therapist?

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PERMISSION TO DISCUSS PHI AND CONSENT

Consent for Leaving Messages ☐ **Yes** **-OR-** ☐ **No**

I consent to information regarding my child's (under the age of 18) or my detailed appointment reminders/instructions be left on my voicemail or answering machine.

Consent for Shared Information with Family & Friends **Yes OR No_____**

The name(s) listed below are family members or friends to whom I grant permission for my therapist and their representatives at Tree of Life Counseling, PLLC to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment.

Under the HIPPA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

In understand that some information, as listed below, is considered "sensitive." I understand that I must check specific boxes in order for my therapist or his/her designee to discuss any "sensitive" information with the listed family or friend.

Mental Health/Psychiatric disorders (including depression) **Yes OR No_____**

AND/OR

Chemical Dependency (drug and/or alcohol abuse/ treatment) **Yes OR No_____**

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

Name	Relationship and Phone Number

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent must provide written notice to the staff at Tree of Life Counseling, PLLC.

In order to obtain information by telephone, the party calling the practice must share the patient's date of birth with the staff. With the exception of parents or guardians, if the party calling is not on this list, the staff will be unable to share any information regarding the patient.

I understand that as part of my healthcare, TLC originates and maintains health records describing my health history, symptoms, diagnosis, treatment, and any plans for future care and treatment. By signing this form, I'm consenting to TLC to use and disclose my health information to carry out my treatment, payment, and healthcare operations (TPO) I also understand this information serves as:

- A basis for planning and my care and treatment;
- A means of communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis to my bill;
- A means by which a third party payer can verify that services were actually rendered;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

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PLACE INITIALS BY EACH CONSENT TO INDICATE YOUR AGREEMENT

_____ I hereby request services from TLC for evaluation and/or treatment. If the evaluation indicates that treatment is appropriate, I consent to such services as may be prescribed by the therapist(s) responsible for my care. If the evaluation indicates that I would not benefit from services available at this practice or that needed services are not offered by the practice I will be referred to a more appropriate resource for assistance. I also understand that the individual who provided consent may revoke it any time as well.

_____ I hereby grant permission for TLC to seek emergency medical services on my behalf if that should become necessary. In the event that emergency medical treatment is necessary, I give permission to TLC to provide necessary information to the hospital, physician and/or emergency medical personnel who will provide these services. Staff of TLC will make efforts to contact my family or emergency contact designee immediately. The practice is not responsible for any charges that are incurred as a result of emergency medical services. **(Name, address and phone number of preferred physician, note "N/A" if no preferred physician):**

_____

_____ I hereby grant permission to TLC to communicate via electronic transmission, including, email, text, and telephone answering machine/voicemail. I understand that information specific to my treatment will not be sent via these means.

_____ TLC is authorized to release information from my patient record to my insurance company in order to process and pay claims for services rendered to me through **Psyquel**. I understand that this consent allows the release of all information in my patient service record including substance abuse, communicable diseases (including AIDS/HIV), and other sensitive documentation as specified in the need.

_____ I hereby authorize payment directly to TLC of any insurance or government program benefits otherwise payable to TLC for services rendered by my therapist. I understand that I am financially responsible for any charges not paid under this assignment. If my visit today is with a therapist that is Non-Covered by my insurance company, I understand that I will be responsible for those charges. Any refunds due to me shall be applied to any other outstanding balance for which I am responsible at TLC. I will notify TLC of any changes in my financial/insurance status.

_____ I acknowledge receipt and/or review of the listed documents and have been given a complete and satisfactory explanation of their contents and purpose:

- TLC Patient Notice and Compliance Practices
- Provider Professional Disclosure Statement
- Policy for Working with Minors (if applicable)
- TLC Financial Agreement
- Permission to Discuss PHI and Consent

I understand all of the statements above. The consents shall be valid until cessation of treatment, revocation of said consents, or to the extent that action based on this consent has been taken. Authorization to Disclosure Health Information or an equivalent will be used to authorize a request for or release of protected health information on my behalf.

_____ _____

Client's/Guardian Legal Signature Date

_____

Client's Printed Name

_____ _____

Guardian Printed Name RELATIONSHIP

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FINANCIAL AGREEMENT

As a courtesy, Tree of Life Counseling, PLLC billing company will attempt to verify your insurance coverage, to determine your financial liability (co-pay, co-insurance, and/or deductible), as well as, file your claim with your benefit plan provider. Your plan may offer therapy coverage, but generally there are eligibility requirements. The benefits that were disclosed to us are what our office had been provided with when we checked your plan. **PLEASE NOTE: This is not a guarantee of benefit or payment. We highly recommend that you contact your insurance carrier to verify benefits, covered services, and limitations. You are responsible for monitoring your utilization of benefits with your benefit plan provider.*

I understand that my insurance is an agreement between the insurance company and myself. I agree to assign payments to be made on my behalf to this provider for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services. I understand that Tree of Life Counseling, PLLC will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied or that are not covered by my insurance company at the time the EOB is received. Your insurance carrier also requires as part of your responsibility towards your plan, is to pay your provider at the time services are rendered. **Payment** is required ***on or before*** the time which services are rendered, either by check, cash, money order, Visa, MasterCard, Discover or Flex Plan cards. In the event that you write a check that is returned for non-sufficient funds (NSF), you will be responsible for the amount written on the check **plus a $25.00 NSF fee** and Tree of Life will no longer be able to accept a check as a form of payment.

Tree of Life Counseling's billing service will file the claim with your insurance company. After your insurance company has paid its portion of the bill, your credit card may be charged for any remaining balance that is your part of the bill. You may request a receipt be sent to your email address. *INVOICES sent by US postal mail or by email prior to charging your card are done so out of courtesy only.* If you *cannot agree* to this payment procedure please call and cancel your appointment. In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I understand that I will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs. *Tree of Life Counseling, PLLC sends all delinquent accounts to American Profit Recovery. Tree of Life Counseling, PLLC does add 24% to the principal balance in order to recover fees associated with settling a delinquent accounts.*

Unless we reach a different agreement, the full fee will be charged to your credit card for sessions missed without such notification (3.75% surcharge will be added):

$160.00 initial session ($166.00) **$120.00 ongoing sessions ($124.50)**

INFO BELOW IS REQUIRED PRIOR TO YOUR FIRST APPOINTMENT
(if this information below changes, you are required to provide us with the new information):

Credit Card Number _____ _____ _____ _____

Expiration Date: _____ / _____

Name of Cardholder as it appears on Credit Card _____

CVV _____ **Zip Code of Card Holder** _____
(3 digit code back of card)

Your therapist will ask you to present your Visa, MasterCard, Discover or Flex Plan card to verify your credit card you placed on file above.

By signing below, I have read, agree with, and understand this financial agreement.

_____ _____
Credit Card Holders Legal Signature Date

_____ _____
Credit Card Holders Printed Name RELATIONSHIP

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