BASICS
COUNSELING & TESTING
A DIVISION OF BASICS GROUP PRACTICE, LLC

NEW CLIENT
WELCOME PACKET

Welcome!

WELCOME TO BASICS GROUP PRACTICE LLC!

This welcome packet contains important information about our professional services and business policies.

Please read it carefully and note any questions you might have so you can discuss them with your therapist during your intake. Once you sign this consent form, it will constitute an agreement between you, and BASICS Group Practice, LLC.

Thank you for choosing BASICS Group Practice!

RICARDO D. LAGRANGE, PH.D.
COO

DANIEL FEREBEE LCSW-C
CEO

BASICS
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INTAKE CHECKLIST

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- THE THERAPY PROCESS
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- INFORMED CONSENT FOR SERVICES CHILDREN/ADOLESCENTS
- FINANCIAL AGREEMENT
- CREDIT CARD AUTHORIZATION

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301.420.1972 | info@basicscounseling.com
7610 Pennsylvania Avenue, Suite 203
Forestville, MD 20747

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CLIENT DEMOGRAPHICS

PERSONAL INFORMATION

CLIENT NAME _____ **PREFERRED NAME (IF APPLICABLE)** _____

PARENT/GUARDIAN NAME (IF APPLICABLE) _____

DATE OF BIRTH _____ **AGE:** _____ **RACE/ETHNICITY** _____

ADDRESS _____

GUARDIAN ADDRESS _____

PHONE NUMBER _____ **E-MAIL** _____

MOBILE NUMBER _____

INSURANCE CARRIER _____ **INSURANCE ID#:** _____

SUBSCRIBER NAME _____

REFERRAL SOURCE _____

CASE MANAGER NAME _____ **PHONE NUMBER** _____

PSYCHIATRIST NAME _____ **PHONE NUMBER** _____

PREVIOUS THERAPIST _____ **PHONE NUMBER** _____

PRIMARY CARE PHYSICIAN **PHONE NUMBER**

EMERGENCY CONTACT DETAILS

CONTACT NAME _____ **HOME NUMBER** _____

RELATIONSHIP _____ **MOBILE NUMBER** _____

OFFICE USE ONLY

DATE COMPLETED _____

PSYCHOLOGICAL TESTING? (Y/N) _____

COURT ORDER? (Y/N)
NOTE: COPY IN CHART _____

ASSIGNED CLINICIAN: _____

STAFF INITIALS _____

NOTES _____

THANK YOU

THE THERAPY PROCESS

CLIENT NAME: _____

NATURE OF COUNSELING SERVICES

Psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation.

Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include significant reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolutions of specific problems. Given the nature of psychotherapy, it is difficult to predict what exactly will happen, but we will do our best to make sure you will be able to handle the risks and experience at least some of the benefits. However, psychotherapy remains an inexact science and no guarantees can be made regarding outcomes.

PROCEDURES

Therapy usually starts with an evaluation. It is our practice to conduct an evaluation that lasts up to 2 sessions. This evaluation begins with an intake interview. By the end of the evaluation, we will offer you an initial impression of what therapy will involve, should you decide to continue. If you have questions about any of the procedures recommended, feel free to discuss these openly.

We will usually schedule one 45-minute session per week at a mutually agreed upon time (under some special circumstances sessions may be longer or more frequent). This appointment will be reserved for you on a regular basis and is considered a standing appointment (i.e., if you miss one week, you will still have the same appointment time the next week). The overall length of psychotherapy (in weeks or months) is generally difficult to predict but is something we can discuss when the initial treatment plan is reviewed with you after the evaluation.

FEES AND REIMBURSEMENT

Evaluation & Intake Interview appointments are $150 for a 60-75 minute session. The fee for individual 60-minute therapy is $125 per session. BASICS also charges special fees for other professional services you may require (such as telephone conversations which last longer than 10 minutes, meetings or consultations that you have requested with other professionals. etc.).

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THE THERAPY PROCESS

In order to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it will usually provide some coverage for mental health treatment when a licensed professional provides such treatment. We will provide you with whatever assistance possible to facilitate your receipt of the benefits to which you are entitled, including completing insurance forms as appropriate. However, you (not your insurance company) are responsible for full payment of the fee.

Carefully read the section in your insurance coverage booklet that describes mental health services and call your insurer if you have any questions. We will provide you with whatever information we have based on our experience and will be happy to try to help you understand the information you receive from your carrier. The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits that often makes it difficult to determine exactly how much mental health coverage is available. Managed health care plans such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short-term treatment approach designed to resolve specific problems that are interfering with level of functioning. It may be necessary to seek additional approval after a certain number of sessions. Although a lot can be accomplished in short-term therapy, many clients feel that more services are necessary after the insurance benefits expire. Some managed care plans will not allow us to provide reimbursed services to you once your benefits are no longer available. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.

Please be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plans or summaries, or in rare cases, a copy of the entire record. This information will become part of the insurance company's files, and in all likelihood, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what your insurer will do with the information. In some cases, the insurer may share the information with a national medical information data bank. The Medical Information Bureau (MIB) is a central database of medical information shared by insurance companies. The MIB does not have a file on everyone. But if you have an MIB file, you will want to be sure it is correct. You can obtain a copy for free once a year by calling (866) 692-6901 (TTY for the hearing impaired (866) 346-3642) or by visiting the company's web site at www.mib.com/html/request_your_record.html.

It is best to discuss all the information about your insurance coverage with your clinician, so you can decide what can be accomplished within the parameters of the benefits available to you and what will happen if the insurance benefits run out before you are ready to end treatment. It is important to remember that you always have the right to pay for counseling services yourself if you prefer to avoid involving your insurer.

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THERAPY PROCESS

CONTACT HOURS

Our office hours are Monday through Friday, 9:00 am to 7:00 pm. Some evening group therapy hours are available. We are generally not available for telephone services but you can cancel and reschedule sessions by calling (301) 420-1972 and leaving a message on the confidential answering service.

If you need to reschedule an appointment, we will make every effort to return your call on the same day, with the exception of calls made after-hours or on weekends and holidays. If you are difficult to reach, please leave some times when you will be available.
If you have an emergency please call the Emergency Room at your nearest hospital, or dial 9-1-1.
Please note that BASICS does not have emergency services or facilities.

RECORD-KEEPING PROCEDURES

Both law and the standards of the counseling profession require that we keep treatment records. You are entitled to receive a copy of these records, unless we believe that seeing them would be emotionally damaging to you. If this is the case, we will be happy to provide your records to an appropriate mental health professional of your choice. Although you are entitled to receive a copy of your records if you wish to see them, we may prefer to prepare an appropriate summary instead. Because client records are professional documents, they can be misinterpreted and can be upsetting. If you insist on seeing your records, it is best to review them with your therapist to discuss their content.

Clients will be charged an appropriate fee for any preparation time that is required to comply with an informal request for record review. If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is policy to request an agreement from parents that they consent to give up access to your records. If they agree, we will provide your parents only general information on how your treatment is proceeding unless there is a high risk that you will seriously harm yourself or another person. In such instances, we may be required by law to notify your parents of our concern. Parents of minors also can request to be provided with a summary of their child's treatment when it is complete. Before giving your parents any information, we will discuss this matter with you and will do the best we can to resolve any objections you may have about what will be discussed.

The State of Maryland requires that we keep your records for 7 (seven) years after termination of counseling services and for minors, 7 (seven) years after the minor turns 18 (eighteen).

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CLIENT SIGNATURE AGREEMENT PAGE

SIGNATURES VERIFYING TREATMENT

Your signature below indicates that you have read the documents in the document entitled, “The Therapy Process”, that you have understood it, and that you agree to abide by its terms as long as you are a BASICS Group Practice, LLC client.

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

The Health Insurance Portability and Accountability Act (HIPAA) establishes patient rights and protections associated with the use of protected health information (PHI). HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, I will do all we can do to protect the privacy of your mental health records. If you have questions regarding matters discussed in this Patient Notification, please do not hesitate to ask.

I. Preamble

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA clearly defines what kind of information is to be included in your "designated medical record" or "case record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers. HIPAA provides privacy protections about your PHI which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations. Treatment refers to activities/sessions this practice provides, coordinates or manages for your mental health care service or other services related to your health care. Examples include a counseling session or communication with your primary care physician about your medication or overall medical condition. Payment is when BASICS Group Practice, LLC obtains reimbursement for your mental health care or other services related to your health care. Health care operations are activities related to the services rendered such as quality assurance. The use of your protected health information refers to activities BASICS Group Practice, LLC conducts for scheduling appointments, keeping records, and other tasks related to your care. Disclosures refer to activities you authorize such as the sending of your protected health information to other parties (e.g., your insurance company).

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HIPAA PRIVACY AUTHORIZATION FORM

II. Uses and Disclosures of Protected Health Information Requiring Authorization

If you request BASICS Group Practice, LLC to send any of your protected health information of any sort to anyone outside this office, you must first sign a specific authorization to release information to this outside party. A copy of that authorization form is available on our website and upon request. In recognition of the importance of the confidentiality of conversations between therapist and clients in treatment settings, HIPAA permits keeping “psychotherapy notes” separate from the overall “designated medical record”. “Psychotherapy notes” are the therapist’s notes “recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual’s medical record.” “Psychotherapy notes” are private and contain information about you and your treatment.

III. Uses and Disclosures Not Requiring Consent or Authorization

By law, protected health information may be released without your consent or authorization under the following conditions:

- Suspected or known child abuse or neglect
- Suspected or known sexual abuse of a child
- Adult and Domestic abuse
- Judicial or administrative proceedings (e.g., you are ordered here by the court)
- Serious threat to health or safety

(e.g.,. “Duty to Warn” and “Duty to Protect”)

V. Patient’s Rights and Our Duties

You have a right to the following:

• The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to but if I do, such restrictions shall apply unless our agreement is changed in writing

• The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want forms mailed to your home address so this office will send them to another location of your choosing.

• The right to inspect and copy your protected health information in the designated record and any billing records for as long as protected health information is maintained in the record.

INITIAL HERE

HIPAA PRIVACY AUTHORIZATION FORM

• The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask for further assistance on these matters. BASICS Group Practice, LLC is required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. BASICS Group Practice, LLC reserves the right to change its privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of these policies when you come for future appointment(s).

Our duties in these matters include maintaining the privacy of your protected health information, to provide you with a notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of the notice unless it is changed and you are so notified.

VI. Complaints

The right to file a grievance is not time limited. If you need assistance in filing a grievance or want further information, please contact:

Maryland Department of Health
Office of Internal Controls and Audit Compliance
Chief Privacy Officer
201 W. Preston Street
Baltimore, MD 21201
410-767-5411 office
410-333-7194 fax
MDH.IAC@Maryland.gov

Please sign, and date this form below to acknowledge that you have familiarized yourself with Confidentiality/HIPAA practices and keep a copy for your records:

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

INFORMED CONSENT FOR SERVICES

Client's Name:
Insurance Company:
Insurance ID#
Date of Birth:

I, _____ herein do voluntarily consent to receive mental health services (i.e. diagnostic assessment, therapeutic services, consultation) from BASICS Counseling Services LLC (hereafter referred to as BASICS).
I understand both the privileges and the requirements associated with the services being rendered by BASICS as stated in the Client's Bill of Rights.

It is understood and agreed by all parties that, unless stated otherwise, this consent form will expire upon completion of services from BASICS. It is further understood that I may withdraw this Informed Consent For Services at any time and for any reason by filling out a Discharge Summary Form.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client at BASICS Group Practice, LLC.

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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INFORMED CONSENT FOR SERVICES FOR CHILDREN/ADOLESCENTS

Client's Name:
Insurance Company:
Insurance ID#
Date of Birth:

I, _____ /
(Name of Guardian)/(Relationship)

of the above named client, herein do voluntarily consent for this child to receive mental health services (i.e. diagnostic assessment, therapeutic services, consultation) from BASICS Counseling Services LLC (hereafter referred to as BASICS).

I understand both the privileges and the requirements associated with the services being rendered by BASICS as stated in the Client's Bill of Rights. It is understood and agreed by all parties that, unless stated otherwise, this consent form will expire upon completion of services from BASICS. It is further understood that I may withdraw this Informed Consent For Services at any time and for any reason by filling out a Discharge Summary Form.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client at BASICS Group Practice, LLC.

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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FINANCIAL AGREEMENT

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible and/or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of the monthly statement. It is also my responsibility to review the Explanation of Benefit (EOB) forms I receive from my insurance so I can track insurance payment for services rendered. I understand that my insurance claims will typically be sent electronically via computer modem to claims processing clearinghouse. This clearinghouse will direct the insurance claim to my insurance company electronically where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions.

By my signature below, and as recorded on the HIPAA consent form, I am giving BASICS Group Practice, LLC permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies. Furthermore, I authorize that payment of mental health benefits be made to BASICS Group Practice, LLC. Any questions that I have about confidentiality can be answered in the Notice of Privacy Practices found in the office waiting room and made available to all clients. I have also signed the HIPAA acknowledgement form and understand my client rights and the rules regarding release of Protected Health Information. I have been informed that I can ask the Privacy Officer any questions regarding confidentiality of records, the complaint procedure, or other matters pertaining to my review of my record.

Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

*Certain special services (e.g. school psychological evaluations, report writing, some types of testing, court-ordered treatment/evaluation) are often not covered by insurance. It is the client's responsibility to determine what services are and are not covered by their health insurance.

If you are being seen for any services other than psychotherapy (e.g., psychological testing), it is strongly recommended you call your insurance carrier to verify coverage.

If you become involved in any legal matter that requires your therapist to testify in Court, or to prepare reports for your attorney or the Court, you will be charged $200.00 per hour for these special services. These services will not be billed to insurance as they are not mental health therapy/evaluation services. YOU WILL NOT NECESSARILY BE REMINDED OF THESE SPECIAL CHARGES.

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FINANCIAL AGREEMENT

I understand that charges will be added to my account for professional services rendered by my therapist (i.e., phone contacts over 5 minutes, preparation of special forms, reports, court time, etc.).

For Court-ordered Custody Evaluations the fee is $250.00 per hour for all services.

I am also aware that I will be charged $75.00 for each appointment that I miss or cancel less than 24 hours in advance. I agree to pay this amount and I understand that this charge cannot be billed to my health insurance carrier.

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I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable. I will not be charged for the canceled session. If I do not pay my outstanding balance for three (3) consecutive billing cycles my account will be turned over to collections.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms.

Client Printed Name

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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FINANCIAL AGREEMENT

ADDENDUM

This brief addendum to our Office Financial Policy is to remind you that as a new client to our office it is very important each time you see your therapist for professional services that you pay your insurance co-payment amount (the amount your insurance policy says you must pay each time), or your self-pay amount (the amount clients without insurance pay), in the form of cash/credit card. If the client is a minor, or adult under guardianship, it is important that the client's parent or guardian make sure they come to each session with the proper payment for services. If the client comes alone, the parent or guardian must make arrangements for payment to be made at the time of the session. Failure to bring your proper payment to each session may result in you not being seen by your therapist that day, and your session may be re-scheduled. This decision is at the discretion of your assigned therapist.

All clients being seen via telehealth services are similarly responsible for making any payments prior to the scheduled session via your online portal, MYIO. Remember, regardless of your insurance coverage, you are ultimately responsible for the balance of your account for the professional services rendered. For this reason, it is VERY important that you track how much your insurance is paying for services. It is also necessary for you to know what your insurance coverage is. ***We check your benefits as a courtesy to you, but you are ultimately responsible for checking on and knowing what your coverage is.***

If your insurance reaches the yearly maximum, or does not cover certain services, you are responsible for tracking that and paying the balance. You can track this by paying close attention to the Explanation Of Benefits (EOB) form that your insurance company will send you.

A bill will be sent every month to clients who owe the Practice money for their portion of the charges. We ask that you make sure at the time of service that you pay any deductible, co-pay, or outstanding balance in order to avoid the extra work and cost of sending out bills or reaching you by phone. We reserve the right to charge interest at the rate of 1.5% per month on all outstanding balances.

If your insurance company denies payment for any services, that amount will be transferred to your balance.

Should your address, name, other identifying information, or insurance coverage change please be aware that it is the responsibility of the client to inform our office immediately.

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FINANCIAL AGREEMENT

ADDENDUM (CONTINUED)

By way of my signature, I am agreeing to the BASICS Group Practice, LLC financial policy as described above We will be glad to continue to deal with the insurance company on your behalf, but you will be responsible for any unpaid charges. We submit insurance claims as a courtesy to you, but it is ultimately your responsibility to know your benefit limits and to obtain payment from your insurance carrier. We need to work together to ensure your insurance carrier pays their fair portion of your bill for services. Remember, you can use a credit card to pay for any services rendered at our office either in person or online through MYIO. We sincerely appreciate your cooperation in helping us keep your account balance paid in full as you receive professional services at BASICS Group Practice, LLC.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms.

Client Printed Name

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy): _____ CVV Code: _____
Street Address:_____ Cardholder ZIP Code: _____
Email Addres:_____ Phone: _____

I authorize BASICS Group Practice, LLC to charge my credit card for the amount below:

_____ cost of the entire therapy session, or
_____ insurance co-pay or deductible
amountI understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

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