533 N. Nova Road Suite #114
Ormond Beach, FL 32174
Phone 386-265-1441 Fax 386-265-4066
info@flcounselingnetwork.com
floridacounselngnetwork.org

NO SHOW POLICY, NO **SHOW FEE**, **AND COLLECTION OF** PATIENT **RESPONSIBILITY**

CANCELLATIONS AND **NO-SHOWS**

If you must cancel or reschedule an appointment, Florida Counseling Network (FCN) requires at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged A NO SHOW **FEE** for the session of **$75.**

PATIENT RESPONSIBILITY

Self-Pay Patient

Payment of the fee for self-pay will be collected no later than the day prior to the appointment. If you are unable to make payment at that time, we will be happy to reschedule your appointment to accommodate Your ability to provide payment.

Insured Patient

Based on your insurance policy regarding Deductible, Co-payment and Co-insurance, it is by law unlawful for us to waive the patient's responsibility. Co-payment is to be collected prior to or at time of service. If you are Telehealth or home bound, we will call prior to your appointment, to collect your Co-payment. Deductible and Co-insurance will be billed to you once your insurance has been billed and processed. Payment of any outstanding balance will be collected prior to your next visit. Statements are typically mailed quarterly.

Patient's Name (printed)

_____

Signature of Patient or Legal Guardian/Representative **Date Signed**

_____ _____

Signature of Witness (Facility Staff Member) **Date Signed**

_____ _____

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Informed Consent to Treatment Form

At my own discretion I am requesting treatment with FLORIDA COUNSELING NETWORK. I know that my treatment may consist of psychotherapy or a combination of psychotherapy and pharmacotherapy. I will be educated to the benefits and potential side effects or reactions that may result from any prescribed medication. I have the right to ask questions regarding my treatment and expect that my questions will be answered to my full satisfaction. If I do withdraw from treatment, I have the right to have a referral to another practitioner for alternative treatment.

I agree to allow FLORIDA COUNSELING NETWORK to make this document a permanent part of my patient record.

Finally, I understand and will expect that all papers and documents concerning my treatment with FLORIDA COUNSELING NETWORK will be kept confidential. No information concerning my treatment can be released without my specific written consent except as required by law or in a situation deemed potentially life-threatening. According to Federal Regulations, licensed providers are mandated to report information that professional judgment would determine constitutes threat or serious harm to self or others or indicates child or elder abuse or neglect. You have my consent, without reservation, to release any such information about me without further written approval.

Patient's Name (printed)

_____

Signature of Patient or Legal Guardian/Representative **Date Signed**

_____ _____

Signature of Witness (Facility Staff Member) **Date Signed**

_____ _____

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TREATMENT CONSENT FORM Page 1

Please read carefully, initial on each page, sign, and date on the last page.

PSYCHOTHERAPY SERVICES OFFERED

Psychotherapy, or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline, and work on both parties for a therapeutic relationship to be an effective one. Clients will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions. Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually, these unpleasant sensations are short lived. On your initial visit, your provider will conduct a thorough review of your current complaints and of your background and discuss your treatment options. Sometimes, psychotherapy alone will suffice. Oftentimes, however, a combination of psychotherapy and medication management is optimal (see below).

One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between therapist and client, so, the initial visit is also your opportunity to determine for yourself if we are the right provider for you. If you feel that we are not well matched to your needs, we would be happy to provide you referrals to other mental health professionals.

MEDICATION

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, your provider will discuss with you all the medication options that are available to treat your current condition. They will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal symptoms you may experience if you stop taking the medication abruptly. By the end of the discussion, you will have all the information you need to make a rational decision as to which medication is right for you. You may already be receiving psychotherapy from another therapist and are referred to FCN for medication management. In this case we will make a strong effort to coordinate care with your therapist (with your consent, of course). We believe communication between mental health professionals is key to providing effective care. Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

Initial _____

Overall, we are a strong proponent of the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

FREQUENCY AND DURATION OF VISITS At your initial visit, you and your provider will decide together the structure of your care. If medications are prescribed, or changed, your follow up visit may be scheduled for 2 weeks instead of a standard 4 week follow up. This is necessary to ensure proper administration and minimize any side effects you may experience. Thereafter, medication management may be scheduled monthly, every 90 days, or in longer intervals depending on your needs. Counseling may be scheduled as agreed upon between you and provider in weekly, biweekly, or monthly intervals.

FEES

Our initial evaluation fee is $350. Follow up medication management is $150. Counseling sessions are $100 (50 minutes). Other miscellaneous services such as filling forms, telephone correspondence, prior authorizations, court hearings, etc. requiring more than 15 minutes of time, will cost $25.00 per 15-minute interval. Fees may be subject to change. If our fees are to increase, we will provide you with a thirty-day notice to alert you to the change.

CANCELLATIONS AND NO-SHOWS

If you must cancel or reschedule an appointment, Florida Counseling Network (FCN) requires at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged **A NO SHOW FEE** for the session of **$**75.

PAYMENTSPayment **is** due at the time **of service.** FCN accepts cash, debit & credit cards. Checks should be made payable to *Florida Counseling Network*. If payment is 60 days past due, FCN reserves the right to utilize legal resources such as collection agencies or small claims court to obtain payment for services.

INSURANCE POLICIES

FCN bills *insurance as* a *courtesy. Denied claims* will ***result* in the *patient's responsibility* to reimburse FCN *for services rendered*. Insurance *coverage* at the time *of* service** is **not a *guarantee* of *payment from insurance companies.*** FCN accepts Traditional Medicare and most Medicare replacement plans. If you are on a PPO plan, FCN will be considered "out of network." If you wish to confirm reimbursement for your sessions, you will need to consult your insurance company to determine their policies regarding mental health benefits for out-of-network providers. Most PPO plans will reimburse between 20%-60% of the fee. Many insurance companies have limitations on the number and frequency of visits, and types of medications that will be covered. Occasionally, certain forms of treatment, or a large number of sessions require prior authorization. If this is the case, your provider may need to provide information about your diagnosis, history, and treatment plan to your insurance company. Once this information is provided, it will be subject to the privacy policies of the insurance provider and is out of our control.

MEDICAL RECORDS

FCN is required by law to keep complete medical records. Most medical records will be electronic and encrypted. Any written records including the initial consent forms, letters, outside medical records, will be scanned into electronic records. The paper records will be destroyed. You are entitled to review your medical record at any time, unless FCN determines that by viewing your records, your emotional or physical well-being will be jeopardized. If you wish to view your records, FCN recommends that they are reviewed together with your provider to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record will be charged the appropriate fee (see above).

Initial _____

CONFIDENTIALITY

FCN is bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary. There are exceptions to this confidentiality, where disclosure is mandatory. These include the following:

If there is a threat to the safety of others, FCN will be required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization.
When there is a threat of harm to yourself, FCN is required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.

If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, FCN will be required to disclose information to seek hospitalization. These situations rarely occur in an outpatient setting. If they do arise, FCN will do their best to discuss the situation with you before taking action. In rare circumstances your provider may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

OUR PRACTICE

FCN is an entity of multiple contracted mental health professionals. Patient medical records are kept secure in a cloud database in which both your medication management provider and counseling provider have access to the records. No person outside of our practice will have access to your records without your written consent. Common access to records between Nurse Practitioner/ Doctor and Counselor is helpful to collaborate and coordinate your care, and this will require your written consent. Each individual provider will be responsible for the care they provide to you.

CONTACT INFORMATION

Our office phone is 386-227-7014. We check our voicemail regularly. When you leave a message, please state your name clearly, your phone number(s) (even if you think we have it), reason for calling, and let us know when the best time is to contact you. Please note that we may be assisting other clients but will make every effort to address your issue as soon as possible. For non-urgent matters, please allow 24 business hours for a response. Messages left late in the day, on weekends or holidays, may not be returned until the next business day. If you or someone close to you is in immediate danger, please call 9-1-1 or proceed to the nearest emergency room.

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand our scope of our services, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of our practice, and our contact information, and that you agree to abide by the terms stated above.

Initial _____

Patient's Name (printed)

_____

Signature of Patient or Legal Guardian/Representative **Date Signed**

_____ _____

Signature of Witness (Facility Staff Member) **Date Signed**

_____ _____

Department of Health and Human Services
Office of Inspector General

IT IS UNLAWFUL TO ROUTINELY WAIVE CO-PAYMENTS, DEDUCTIBLES, COINSURANCES OR OTHER PATIENT RESPONSIBILITY PAYMENTS.

This includes services deemed as "professional courtesy" and "TWIPS-Take what insurance pays". Absent financial hardship, a "good faith effort" **must** be made to collect all deductibles and co-payments due and owed.

Failure to comply makes you in violation of the

(1) Federal False Claims Act

(2) Federal **Anti-Kickback Statute**

(3) Federal and State Insurance Fraud **Laws**

and may result in civil money penalties (CMP) in accordance with the new provision section **1128 A(a) (5)** of the Health Insurance Portability and Accountability Act of **1996 [**section **231(h)** of **HIPAA]**.

For any questions please contact:

Office of Inspector General
Department of Health and Human Services**:**
By Phone**: 202 619-1343**
By Fax**: 202 260-8512**
By E-Mail: paffairs@olg.hhs.gov
By Mail: Office of Inspector General
Office of Public Affairs
Department **of** Health and Human Services
Room **5541** Cohen Building
330 Independence Avenue**,** S.W.
Washington**,** D.C. **20201**

Joel Schaer
Office of Counsel **to** the Inspector General **(202) 619-0089**

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Credit Card Authorization

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

Credit **Card Information**

Card Type __MasterCard __VISA __Discover __AMEX

__Other

Cardholder Name (as shown on card):

_____

Card Number:

_____

Expiration Date (mm/yy): _____ **CVV:**_____

Cardholder ZIP Code (from credit card billing address): _____

I _____authorize Florida Counseling **Network** to charge my credit card above for agreed upon purchases (Copay). I understand that my information will be saved to file for future transactions on my account.

Customer Signature_____ Date_____