



Statement of Confidentiality

Our policy at CoHear is that all information given by a client in an individual session with a therapist/counselor is confidential and will not be revealed to any person or agency without the client’s written release. The laws of Washington State are more lenient than our company policy. However, it is our philosophy and policy to uphold the maximum client confidentiality possible, under the laws.

Washington State law requires healthcare professionals to reveal information to others, with or without the client’s permission, in the following situations. Our policy is to inform the client if at all possible before reporting such a situation.

- a. If a client intends grave bodily harm to another person.
- b. If a client intends grave bodily harm to him/herself.
- c. If a court of law issues a court order to reveal information.

If a situation of current child abuse, elderly abuse, or abuse to a developmentally disabled person is revealed. CoHear’s policy further applies to reporting child abuse, elderly abuse, or abuse to a developmentally disabled person which has occurred not only currently, but at any time.

A healthcare provider may disclose healthcare information about a patient without the patient’s authorization to the extent a recipient needs to know the information, if the disclosure is to:

- a. A person who the provider reasonably believes is providing healthcare to the patient; or
- b. Members of the patient’s immediate family, or any other individual with whom the patient is known to have a close personal relationship.

There are several other circumstances in which people may obtain your records. Under this law, if the patient wishes to not have their healthcare information disclosed they are to sign a form stating that they do not wish to have their healthcare information disclosed without written consent.

CoHear keeps a record of the healthcare services we provide you. You may ask us to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law compels us to do so. You may also ask us to correct that record. You may see your record or get more information about it from your therapist.

I have read and fully understand this statement of confidentiality.

Client/Guardian/Client Representative

Date

Witness

Date



Individual Data

Date _____ Sex: Male ___ Female ___ SS# _____

Client Name _____ Date of Birth _____

Address _____

City / State / Zip _____

Phone: Home _____ OK to call you at Home? _____

Phone: Work _____ OK to call you at Work? _____

Name of Spouse or Partner (if applicable) _____

Person to Contact in Event of Emergency _____ Phone # _____

Guarantor Information (complete only if not client)

Person Responsible For Payment _____

Billing Address _____

City / State / Zip _____

Phone _____ Work _____ SS# _____

Relationship to Client _____ Employer _____

Insurance Information (please provide your card for photocopy)

Name of Insurance Company _____

Address _____ Phone _____

Insured _____ Relationship to Client _____

Policy # _____ Group # _____ ID# _____

Is This a Managed Care Plan? YES ___ NO ___ Have You Obtained Authorization? YES ___ NO ___

Name of Managed Care Company _____

Do You Have a Referral From Your Primary Care Physician? YES ___ NO ___

Name of Primary Care Physician _____ Phone _____

Medical Information

Current Medications _____

Pertinent Medical History _____

Referral Source

Name of Person Who Referred You To This Office _____

Signature of Client or Guardian _____

Questions To Ask A Potential Therapist

1. My concerns or problems are...
2. What would your approach be in working with me?
3. How long have you been in practice? Briefly describe your experience.
4. How much of your practice consists of working with people with similar kinds of problems as mine?
5. How successful have you have been at helping people with my problem?
6. Do you believe family members should be involved at any point in my treatment?
7. What are your credentials (degree, license, certifications, etc.)?
8. What are your thoughts about medication?
9. What is your fee schedule?

It is perfectly acceptable to be assertive and cautious when you make this important choice. Trust your "hunch"



Acknowledgement of Receipt of Notice of Privacy Practices

Patients Name: _____ Patient ID# _____

I hereby acknowledge that I have received a copy of CoHear’s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative

Date

Printed Name of Patient’s Representative (if applicable)

Relation to Patient (if applicable)

- Parent or Guardian of unemancipated minor
- Court appointed guardian
- Executor or administrator of decedent’s estate
- Power of Attorney

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained because:

- Patient/Representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later time)
- Communication barriers prohibited obtaining acknowledgement (Explain) _____

Other (Specify) _____



Authorization For Release of Health Care Information

I, _____, hereby give my consent for:

_____ to;

(Therapist's Name)

Release Information

Exchange Information with

Obtain Information from

Other

To/With/From:

Name: _____

Address: _____

Phone: _____ Fax: _____

Description of Information to be released: _____

Purpose of disclosure: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of Client: _____

SS#: _____ Date of Birth: _____

Dated: _____

This authorization will expire on _____ or in ninety (90) days, whichever comes first, and may be revoked at any anytime.

Witness Signature _____ Date _____



Welcome To CoHear

While you are waiting, please look through the information included in this folder. The three forms following this page need to be completed and signed prior to your first session begins. The forms are

1. Individual Data
2. Contract and Disclosure
3. Statement of Confidentiality

Information about our fees can be found on the back of the Contract and Disclosure sheet. Also in this folder is an Authorization for Release of Health Care Information.

DO NOT COMPLETE THIS FORM AT THIS TIME. You and your therapist will complete this form if information needs to be exchanged with a third party. The final two pages in the folder contain information about CoHear, Inc., including profiles of our staff and a list of counseling services available through our program. These two pages are for your information, and you may feel free to take them with you. Please keep this folder with you after you have completed the forms, and give it to your therapist at the start of your session.

INSURANCE:

Many of the services provided by thr therapist at CoHear, Inc are covered by health insurance carriers. Depending on your coverage, if appropriate, we will bill your insuraqnce as a courtesy to you. While we make every effort to determine whether and how much your health insurance benefits apply, CoHear, Inc .makes no representation or guarentee that the services we provide are covered. ***If your insurance carrier denies your claim for benefits, you will be responsible for the fees for services that we have provided for you.*** Cohear, Inc has *contracted* with some insurance companies as a preferred provider. ***If we are contracted with your insurance carrier,*** we will agree to accept the contract rated for the services rendered and we will bill the insurance for you. You will be asked only ot pay the co-pay, or the client portion of the fee, at the time the services are rendered.

If we are not contracted as a preferred provider with your insurance carrier, you will be responsible for the full amount of the fees for the services rendered to you. Under some circumstances, we may be willing to bill your insurance carrier and accept payment of the co-pay, or client portion, at the time the service is rendered. If your insurance company imposes their own rate of usual and customary fees, you will be responsible for the difference between the amount of the fee and the amount the insurance company allows for the service.

Any direct payment to you from your insurance company will be your responsibility to apply this payment toward any outstanding balances you may have with us.

Your signature below indicates that you have read and understood this information regarding terms of payment and insurance considerations, and that you have had an opportunity to ask any questions that you may have about these issues.

Client Signature _____

Client Name (please print) _____ Date _____



Contract And Disclosure

CoHear agrees to provide professional counseling services on the terms set forth below. The undersigned client agrees to such terms.

1. FEES. Each counselor has an individual fee per the "Fee Schedule" on the back of this contract. The fee(s) charged for a specific session will be determined by 1) the counselor(s) fee and the length of the session(s); or 2) a flat fee that is a portion of an evaluation fee. Clients with no insurance coverage should pay in full at time of service.

2. CANCELLATION. If an appointment is canceled by the client with less than 24 hours notice, the client shall pay the mil fee for the scheduled session. If the appointment is canceled by CoHear with less than 24 hours notice to the client, the client shall receive a credit of one free session equal in length to the session which was canceled.

3. CONFIDENTIALITY. Matters disclosed to CoHear by clients will not be shared with any third party without the prior written consent of the client, unless required by law (please reference our Statement of Confidentiality). We expect each individual client, as well as individual group member, to respect the confidentiality of each individual participating in the opportunities offered by CoHear.

4. RESPONSIBILITY. CoHear understands and respects its full responsibility for the delivery of its professional services, and the client hereby acknowledges his, her, or their responsibility for their own personal growth as clients.

5. COUNSELOR INFORMATION. CoHear provides the enclosed Staff Profiles about each counselor's education, training, experience, and expertise.

6. INSURANCE PROCEDURES. Clients insured by companies with whom CoHear has no services contract should pay in full at time of service. Clients insured by companies with whom CoHear has a service contract should pay their co-pay at time of service and any additional amounts (if any) after payment by the insurance company.

Insurance charges will be submitted regularly to the insurance companies for clients with health care coverage. Please provide a copy of the insured's medical card and complete an Insurance Request Form so that CoHear has the information needed to submit the client billing.

7. RETURNED CHECK CHARGE. If the client's check is returned to CoHear by the bank for any reason, the client agrees to pay an additional \$25 NSF fee on the next visit or on the next billing, whichever is sooner. The client has been provided a copy of this required disclosure information and the client has read and understands the information provided.

Client: _____ Witness: _____

Client: _____ Date: _____