CHILD/YOUTH INTAKE

Phone: 601-939-6634
Fax: 601-420-9252
www.crossroadscounselingms.com

Date: _____

MINOR'S PERSONAL INFORMATION (Under age 18):

Client Full Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Leave Msg? ❒ YES ❒ NO Cell Phone: _____ Leave Msg? ❒ YES ❒ NO

Work Phone: _____ Leave Msg? ❒ YES ❒ NO Other Phone: _____ Leave Msg? ❒ YES ❒ NO

Gender: ❒ Male ❒ Female Employment: ❒ Employed ❒ Full Time Student ❒ Part Time Student ❒ Other

Birth Father's Name: _____ Birth Mother's Name: _____

Step-Father's Name: _____ Step-Mother's Name: _____

Emergency Contact Name: _____ Emergency Contact Home Phone: _____

Emergency Contact Cell Phone:_____

Relation to emergency contact: ❒ Father ❒ Mother ❒ Step-Father ❒ Step-Mother ❒ Legal Guardian ❒ Other

Please list the name(s) of anyone with whom you would like your therapist to communicate regarding minor's therapy:

_____

If a child custody order or other temporary order is in effect setting forth the custody arrangement for the minor client, Crossroads Counseling Center must be provided a copy of said Order immediately.

MINOR'S BILLING INFORMATION:

Billing Full Name of responsible party: _____

Billing Address of responsible party: _____City:_____ State: ___ Zip:_____

Responsible party DOB: _____ Responsible party SS#: _____

Billing Phone:_____ Leave Msg? ❒ YES ❒ NO Email Address: _____

Receive Statement via: ❒ Email ❒ U. S. Postal Service

Relation to Client: ❒ Parent(s) ❒ Step-Parent(s) ❒ Legal Guardian ❒ Other

Involved in litigation? (NO) (YES). If yes, you must explain in detail to your counselor and provide adequate documentation if you desire their professional services in the matter as there are strict policies and additional fees other than the normal counseling fees.

Payment for Services: I clearly understand that I am ultimately responsible for payment for services Not my insurance company. If you are experiencing circumstances out of your control, please talk with your counselor or the office representative to discuss possibilities of a mutually agreeable financial payment plan.

All balances are immediately payable upon termination or long-term suspension of treatment.

TWENTY-FOUR (24) HOUR CANCELLATION NOTICE: To cancel an appointment a 24-hour advance notice is required. Failure to do so may result in charges for the entire session. Insurance does not pay for these charges. Anything longer than 15-minutes late is considered a missed appointment.

Telephone Conversations- Time on telephone conversations with your therapist other than appointment information is charged at the prorated hourly charge.

Court Documentation, Deposition and Testimony Fees: Fees for court documentation and legal services are in addition to normal charges for counseling and therapy. Be sure to inquire about policies and ask for a rate chart as they are billable at predetermined rates.

All fees must be paid in full before any work is performed in relation to deposition, court and expert witness testimony and must be paid in full no later than ten days prior to any testimony. Although our policy is not to participate in litigation unless we agree to do so, the fees set forth herein are in recognition that a client or litigation may attempt to force testimony through the court process in order to circumvent our fee structure. In the event that this occurs, we will resist all efforts to procure our testimony without adequate compensation and our agreement and will ask the court to impose the fee structure herein as a condition of our testimony. By signing below, you are accepting this as a condition of our firm providing therapy and counseling.

If a person responsible for payment defaults on any payment obligation as called for in this agreement, Crossroads Counseling Center will have the right to take any legal action to collect the debt. By signing this agreement, you are acknowledging and agreeing that should Crossroads Counseling Center turn this matter over to an attorney for collection or if it initiates litigation against you for any delinquent debt, that you agree to be responsible for paying all of Crossroads Counseling Center's attorney's fees and expenses incurred as a result of the collection efforts.

By signing below, I agree to all of Crossroads Counseling Center's policies and understand that I am bound by the policies if I sign below. I understand that if I sign via electronic signature, my consent is still valid.:

Billing Signature(s) - Required for Services _____ Date: _____

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INSURANCE BILLING INFORMATION AND AUTHORIZATION FORM

- **We are in-network providers for Blue Cross & Blue Shield of Mississippi, Blue Cross Federal and AHS State Health Network and AETNA. As a courtesy to you, we work directly with your insurance and will make every effort possible to bill your insurance company.**
- **It will be important for you to understand your benefit coverage. For benefit coverage questions, please call the customer/member service number on the back of your insurance card.** *The insurance verification worksheet provided on our website can assist you during the call.* **It is your responsibility to check before your initial visit to know your plan's limitations, deductibles and exclusions.**
- **Verification of benefit coverage is not a guarantee of claim payment. All benefits are subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company. We have no authority to make representations to you regarding coverage of items or services covered.** ***Some plans require pre-authorization*****. It is your responsibility to engage this process with your insurance company before expecting insurance payment.**
- **In the event verification of benefit coverage cannot be obtained by either CCC or the Primary Insured prior to the first appointment, you are responsible for paying the entire fee for the first three sessions until payment is firmly established with the insurance provider. Once payment from insurance is established, you will only be responsible for the co-pay or co-insurance.**

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- **In compliance with health insurance contracts, CCC requires that all co-payments, co-insurance and deductible amounts are collected at the time of service. We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company. Per your agreement with your insurance company, it remains your responsibility to immediately pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you.**
- **It is your responsibility to provide us with updated information if your insurance company changes or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for the amount denied by your carrier.**
- **You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.**
- **Because we are a "fee for service" provider, billing statements from CCC will not automatically be sent – should you need a statement or payment itemization, please inform your therapist, and we will provide this for you upon request.**

It is important that you thoroughly complete this form and provide a copy of both sides of your insurance card.

PRIMARY INSURANCE INFORMATION: *(The Primary is the policy holder)*

Name of the Insured: _____Primary's Date of Birth: _____SS#:_____

Primary's Address: _____City: _____ State _____Zip_____

Gender: ❒ Male ❒ Female Subscriber ID#/Policy #: _____

Client Relationship to the Primary Insured: ❒ Self ❒ Spouse ❒ Child ❒ Other Relationship

I authorize CCC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Crossroads Counseling Center. I will not hold CCC liable for insurance nonpayment due to misquoted benefits. I acknowledge I am responsible to know and understand my benefits plan. CCC will file my primary insurance claims for me as a courtesy. I understand that I am responsible for payment for services rendered by Crossroads Counseling Center, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Crossroads Counseling Center immediately whenever I have changes in my health plan coverage in the future. I also request that assigned benefits be paid to CCC and/or the provider indicated above. I understand that if I sign via electronic signature, my consent is still valid.

_____ Date: _____

Signature of Client and/or Insured: - Required to bill insurance

NOTICE AS OF 01/01/2022 for Uninsured and Self Pay Clients

Crossroads is compliant of the Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act) requiring all professional service providers to give uninsured and self-pay patients a good faith estimate of costs for services that they offer, when scheduling care or when the patient requests an estimate and prohibit providers from balance billing "surprise bills" to patients for emergency and certain non-emergency services provided at facilities. A good faith estimate must be provided within 3 business days upon request. Information regarding scheduled items and services must be furnished within 1 business day of scheduling an item or service to be provided in 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days. Disclaimer: All Good Faith Estimates will show the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

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CONFIDENTIALITY POLICY

Crossroads Counseling Center, (henceforth, referred to as CCC), takes confidentiality seriously, and we desire to provide an environment in which our clients may place their trust and confidence. Your therapist will keep all information regarding your identity, evaluation, treatment, and related records in confidence. The State of Mississippi laws impose some limitations to your rights to confidentiality. These exceptions include:

- Mandated reporting of physical or sexual abuse of a child or vulnerable adult
- Diagnosis, written treatment plans, and dates of service will be shared with your insurance company for collection of payments and continuation of therapy
- Threats of suicide or homicide
- When written consent is obtained from you to release information
- Information necessary for supervision or consultation
- Information released as outlined in the HIPAA Notice of Privacy Practice
- Information in the course of therapy with a minor dependent which clinically requires disclosure to their parent or legal guardian. (A verbal explanation for disclosure will be made to the minor child during the session.)
- Other as required by law, court order, or in the event of litigation.

Your signature indicates consent to use your personal health information for routine practices according to the law for treatment, payment, and health care operations. You may revoke this consent in writing at any time, except to the extent that CCC has taken action relying on this consent. I understand that if I sign via electronic signature, my consent is still valid.

CLIENT SIGNATURE – Required for Services _____ **DATE:** _____

ACKNOWLEDGEMENT AND CONSENT TO USE ELECTRONIC COMMUNICATION AND TECHNOLOGY

There is ongoing advancement of technology and expansive means of communication (e.g. email, text messaging, twittering, social networking sites, etc.). The most secure exchange of confidential information is face to face. CCC prioritizes confidentiality and therefore desires to avoid communication via means in which your identity cannot be verified or in which others may be exposed to the confidential information sent by the therapist. However, CCC understands that you may prefer to exchange information via email or text messaging to communicate with your therapist.

I have been advised and understand that the use of email, cell phone texting, and other forms of technology in psychotherapy has not been defined as a best-practice strategy. I have also been specifically advised of the following:

1. Email/texting communication with my therapist or CCC will be used for the purpose of simplifying and expediting scheduling/administrative matters only.
2. Email/texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Therefore, email/texting should NOT be used to communicate:
   - Suicidal or homicidal thoughts or plans
   - Urgent or emergency issues
   - Serious or severe side effects or concerns
   - Rapidly worsening symptoms
3. In a life-threatening emergency, clients should: Call 911 and proceed to the nearest hospital emergency room or contact a crisis hotline.
4. Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. No technology is 100% secure and the therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically.
5. The use of email, cell phone, or other forms of technology does not change the fact that the services provided by my therapist are psychotherapy sessions scheduled and confirmed by both parties in advance of the sessions. CCC does not provide crisis intervention,and email/cell phone texting is not a reliable way of obtaining urgent help from the therapist in an emergency.

I have thoroughly considered all of the above information and I understand and agree that if I choose to communicate with my counselor through email and/or text messaging, my therapist will not be held liable for exposure of confidential information.

By signing, I consent to the use of email/cell phone texting as needed for scheduling and administrative purposes only, within the guidelines above. If more urgent help is needed, I will utilize the crisis services listed above in Line 3. Furthermore, If, at any time my therapist or I believe email/texting is interfering with my therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding. I understand that if I sign via electronic signature, my consent is still valid.

CLIENT SIGNATURE – Required for Services _____ **DATE:** _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing mental health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your mental health care and any related service. This includes the coordination or management of your mental health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for psychological testing or a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for the psychological testing or hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; food and drug administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity; military activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your therapist or the therapist's practice has taken

action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of rights with respect to your protected health information.

- You have the right to inspect and copy your protected health information. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.
- Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice becomes effective on or before April 14, 2003.

I have received a copy of my privacy rights under the Health Insurance Portability Act. I agree to all of these policies and I understand that I may contact this office to make any changes I require. I understand that if I sign via electronic signature, my consent is still valid.

CLIENT SIGNATURE _____ **DATE:** _____

INFORMED CONSENT FOR PROFESSIONAL SERVICES AGREEMENT : My signature below indicates that I voluntarily agree to participate in the assessment and counseling as offered by Crossroads Counseling Center. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in this document. I acknowledge receipt of this document and all the information contained in this document along with the **HIPAA Privacy Practices**. I agree that my therapist may withdraw and will not be obligated to provide counseling services if I fail to abide by the terms specified in this document. **By my signature below**, I certify that I am not under a legal disability that prevents me from understanding the terms of this agreement, and I accept all the terms and conditions as herein stated.

It is understood and agreed that I as a client will never tape a session without the express written consent of the therapist. Any acts to tape a session without the knowledge of the therapist invalidates the client/therapist relationship contracted herein.

By signing below I/We acknowledge being informed that the counselor with whom we are contracting for professional counseling services is operating as a sole-proprietor not participating in partnership with the other counselors at Crossroads or employed by Crossroads Counseling Center. Crossroads provides administrative support as a professional service for each counselor's sole proprietorship. I understand that if I sign via electronic signature, my consent is still valid.

Client Signature(s) - Required for Services _____ Date: _____