clear direction
Crossroads
counseling & life coaching

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME:_____ **DATE OF BIRTH:**_____

I, _____, authorize ***Crossroads Counseling & Life Coaching*** to:
Client Name

CHECK ALL APPLICABLE> ☐ **Release to** ☐ **Request from** ☐ **Verbally exchange**

with the following facility or person:

Name: _____

Facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Information Requested for service dates _____ **to** _____**:**

☐ All items in this section	☐ Financial	☐ Medical records
☐ AODA evaluation/treatment	☐ IEP's and school behavior records	☐ Psychiatric Medical Records
☐ Appointments	☐ Joint Sessions	☐ Psychological testing/evaluation
☐ Confirmation of Contact	☐ Phone/Email contact	☐ Psychotherapy notes

☐ Other: _____

Purpose of Release:

☐ Coordination of Care	☐ Further Medical Care	☐ Legal Investigation or Action
☐ Diagnostic Evaluation	☐ Insurance Eligibility/Benefits	☐ Treatment Planning

☐ Other: _____

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: _____.

Your Rights With Respect To This Authorization:

- Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.
- Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Expiration Date: I understand that this consent can be withdrawn by me in writing at any time except to the extent that action has already been taken in reliance thereon. Unless revoked earlier, or otherwise specified above, this consent will expire in twelve (12) months from the date signed.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client: _____ **Date:** _____

Signature of Parent, Guardian or Authorized Person:_____ **Date:** _____

If signed by person other than patient, state relationship and authority to do so.

Patient is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Deceased**

Legal Authority: ☐ **Parent of minor** ☐ **Power of Attorney** ☐ **Next of kin (Spouse of living)** ☐ **Legal guardian (Attach proof)**

Employee Verification Initials: _____ **REV 4/25/23**

Vision Statement: To provide clear direction and empower clients physically, emotionally, and spiritually in their everyday lives.

clear direction

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Signature of Client: _____ **Date:** _____

Signature of Parent, Guardian or Authorized Person:_____ **Date:** _____

If signed by person other than patient, state relationship and authority to do so.

Patient is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Deceased**

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REV 4/25/23

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REFUSAL FOR DISCLOSURE OF HEALTH INFORMATION

_____ Please initial if you (or your child) have a Primary Care Physician and choose not to sign a release of information to the PCP.

_____ Please initial if you (or your child) have another behavioral health clinician (i.e. psychologist, psychiatrist, counselor) involved in your (or your child's) care and choose not to sign a release of information.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Employee Verification Signature Date

REV: 4/12/23

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CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

Client Name: _____ DOB: _____

COUNSELING FEE SCHEDULE:

SERVICE	Full Charge	Insurance Allowed Charge	Self Pay - due same day
Assessment (done at initial appt and annually)	$312	Determined by Insurance	$200
30 Minute Individual Counseling	$175		$90
45 Minute Individual Counseling	$188		$120
60 Minute Individual Counseling	$200		$150
60 Minute Family w/out Client Counseling	$175		$125
60 Minute Family w/Client Counseling	$200		$150
Materials Testing Fee - NOT reimbursed by ins	$50	NA	$50

STATEMENT OF CLIENT FINANCIAL RESPONSIBILITY:

- I understand the Materials Testing Fee of $50 required prior to first appointment for clients scheduled for psychological testing, neuropsychological testing, ADHD testing or Autism testing.
- I understand payment is due at the time of service, and I am ultimately responsible for payment of my bill.
- I understand that if Crossroads is unable to collect payment from the individual listed as the Guarantor (person(s) responsible for financial billing), I will be ultimately responsible for payment in full.
- I understand this responsibility obligates me to ensure payment in full of Crossroads' fees.
- I understand as a courtesy, Crossroads will verify my coverage and bill my insurance carrier.
- I understand it is my responsibility to obtain pre-authorization for services when required by my insurance carrier and to make Crossroads aware of this requirement.
- I understand I am responsible for payment of any deductible and co-payment/co-insurance as determined by my contract with my insurance carrier, and I am responsible for any amounts NOT covered by my insurer.
- I understand many insurance companies have additional stipulations that may affect my coverage.
- I understand that it is my responsibility to know whether my insurance requires a doctor's referral. If that is the case, it is my responsibility to coordinate the referral and provide Crossroads with the necessary information before my first appointment. Failure to provide a required referral may result in patient responsibility for all charges.
- I understand if my insurance carrier denies any part of my claim, or if my counselor or I elect to continue past my approved dates of service, I will be responsible for my balance in full.
- I understand that I must provide updated insurance information annually and/or if there are any changes in my insurer or policy information. I will be responsible for any charges due as a result of untimely filing caused by failure to provide this updated information to Crossroads.
- I understand if I do not have health insurance I will be financially responsible for services rendered at Crossroads Counseling & Life Coaching, LLC.
- I understand that Crossroads Counseling & Life Coaching, LLC does not accept Medicaid or any other state aid insurance policy.
- I understand that if I have a private insurance policy and Medicaid, I will be responsible for the balance due after my private insurance has been processed.
- **I understand that if I cancel my initial assessment appointment at any time after scheduling, I will be responsible for a $150 deposit to my account prior to rescheduling the assessment. This deposit will be applied to any out-of-pocket costs incurred on my account.**
- **I understand that if I give less than 24-hour notice, I am responsible for a cancellation fee of $100 for an appointment with a counselor and $135 for an appointment with a psychologist, which must be paid prior to the next scheduled appointment.**
- I understand there will be a $25.00 fee for all returned checks.
- I understand that if I request a copy of my medical records, a fee of $.25 per page or a maximum of $25.00 will be charged to compensate the office staff for their time, effort, and supplies.

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT, continued – page 2 of 3

Client Name: _____ DOB: _____

- I understand that the clinicians at Crossroads Counseling and Life Coaching, LLC have a policy to not get involved in court cases if at all possible due to their focus on the therapeutic needs of their clients. If my reason for seeking services is to get professional testimony or written evidence for court proceedings, I should inform Crossroads Counseling and Life Coaching, LLC prior to my intake appointment so they can make an appropriate referral.
- I understand that if the clinicians at Crossroads Counseling and Life Coaching, LLC are subpoenaed for my legal issues (or the legal issues of my child), an out-of-pocket flat fee of $800 will be charged upfront to compensate the clinician on their time, energy, and preparation.
- I understand Crossroads reserves the right to seek legal means to secure reimbursement if financial arrangements are not met. This may include action through the Small Claims Court or a third- p a r t y collection agency.

I have read and agree to the above Statement of Financial Responsibility to Crossroads Counseling & Life Coaching, LLC, for providing mental/behavioral health services to me or the above-named client.

Client Initial: _____

NO SHOW/CANCELLATION POLICY:

- Counseling appointments range from 30 to 90 minutes in duration.
- I agree to attend all scheduled appointments. Crossroads' counselors reserve this time for your appointment.
- I understand I must provide **24-hour** notice if I need to cancel an appointment and not be charged.
- I understand the reminder call is a courtesy and I am still responsible to know when my appointment is.
- I understand that if I give less than 24-hour notice, I am responsible for a cancellation fee of $100 for an appointment.
- I understand insurance companies will not pay for missed appointments.
- I understand that if I am over 15 minutes late, my appointment may be cancelled, and I will be responsible for the cancellation fee of $100 which must be paid prior to my next scheduled appointment.
- I understand I will need to pay the cancellation fee in order to reschedule my appointment.
- I understand if I provide no notice of cancellation of an appointment, I will be responsible to pay the cancellation fee of $100 prior to my next scheduled appointment.
- Frequent cancellations will result in the loss of services.

I have read and agree to the above NO SHOW/CANCELLATIN POLICY for Crossroads Counseling & Life Coaching, LLC, in regards to providing mental/behavioral health services to me or the above-named client.

Client Initial: _____

CREDIT CARD ON FILE AGREEMENT: **NOTE for Telehealth Services** – client portion of fee is due at each date of service.

I authorize Crossroads Counseling & Life Coaching, LLC to retain my credit card on file with the secure payment processor, BillerGenie. I understand that I will need to provide a credit card on file for payment of the client portion of all telehealth services and may elect to have a stored credit card on file for all office services, also. I agree to have payments charged to my credit card at each date of service or per a separate authorized payment agreement with Crossroads Counseling & Life Coaching. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Crossroads Counseling & Life Coaching, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

I have read and agree to the above CREDIT CARD ON FILE AGREEMENT for Crossroads Counseling & Life Coaching, LLC.
Client Initial: _____

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CLIENT FINANCIAL RESPONSIBILITY AGREEMENT, continued – page 3 of 3

Client Name: _____ DOB: _____

PAYMENT AGREEMENT

****NOTE: Social Security number required for: TriCare, Medicare, VA, and EAP****

CHOOSE YOUR PAYMENT METHOD **– Mark either Insurance (& Secondary Insurance, if applicable) OR Self-Pay:**

☐ **PRIMARY INSURANCE** (Card Copy Required):

Policy Holder: ☐ **Client** ☐ **Guarantor** ☐ **Other**	**Subscriber Cell Phone:**
Client Relationship to Subscriber:	**Subscriber Email Address:**
Subscriber Name (Policy Holder):	**Insurance Company:**
Subscriber Social Security #: **Subscriber Date of Birth (MM/DD/YYYY):**	**Insurance ID# or Medicare ID #:**
Subscriber Address:	**Insurance Group Number:**

☐ **SECONDARY INSURANCE** (Card Copy Required):

Policy Holder: ☐ **Client** ☐ **Guarantor** ☐ **Other**	**Subscriber Cell Phone:**
Client Relationship to Subscriber:	**Subscriber Email Address:**
Subscriber Name (Policy Holder):	**Insurance Company:**
Subscriber Social Security #: **Subscriber Date of Birth (MM/DD/YYYY):**	**Insurance ID# or Medicare ID #:**
Subscriber Address:	**Insurance Group Number:**

☐ **SELF PAY: (Due at each session / Telehealth Sessions need to have Credit Card on file)**
☐ **Credit Card** ☐ **Cash or Check**

☐ **CREDIT CARD ON FILE:**

Name on Card:	**Card Number:**
Expiration MM/YY:	**Zip Code:**

I have read and agree to the above Statement of Financial Responsibility, No Show/Cancellation Policy, Credit Card On File Agreement, and Payment Agreement regarding my financial responsibility to Crossroads Counseling & Life Coaching, LLC, for providing mental/behavioral health services to me or the above-named client.

Client Signature _____ Date _____

If guarantor is not the client, please sign below:

Guarantor Signature _____ Date _____ **REV 12/19/23**

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CLIENT INFORMED CONSENT, AGREEMENT, AND AUTHORIZATIONS

CLIENT NAME: _____ **DATE OF BIRTH:** _____

CLIENT AGREEMENT

I agree that during the time that I am an active client of Crossroads Counseling & Life Coaching, I will cooperate to the best of my ability to keep the company informed of my place of residence, employment status, and my progress. I understand that Crossroads Counseling & Life Coaching is open Monday through Thursday as designated as "Hours of Operation." If I need to reschedule an appointment, I will make every effort to call at least 24 hours in advance. If I provide less than 24 hours notice of a cancellation there will be a cancellation fee as described in the No Show/Cancellation Policy. If at any time I decide to stop treatment at this company, I agree to inform my therapist. I understand that my counselor is not available outside of business hours and does not use a business cell phone or check messages during non-business hours. If I am in crisis and my therapist cannot be reached at Crossroads Counseling & Life Coaching I can call 1-800-322-7143 after hours or 911. (_____)

INFORMED CONSENT FOR TREATMENT

I am aware that Crossroads Counseling & Life Coaching staff will conduct all or part of my care. I have been informed of services offered, and understand the risks and benefits inherent in the recommendations provided by Crossroads Counseling & Life Coaching. I understand my participation in treatment may generate stress and/or emotional discomfort as I address issues identified in treatment. I understand that my treatment plan may be revised periodically due to my progress or lack of progress. I recognize that the practice of mental health treatment is not an exact science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment. I hereby consent to the treatment provided by Crossroads Counseling & Life Coaching and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. I have proper legal status to give consent to treatment. (_____)

INFORMED CONSENT FOR EMAIL COMMUNICATIONS

I understand that all e-mail messages are sent over the internet and are not encrypted, are not secure, and may be read by others. I understand that my initial e-mail communications with Crossroads Counseling and Life Coaching staff will not be encrypted and, therefore, neither my counselor nor Crossroads can guarantee the confidentiality and security of any information I send to anyone at Crossroads or that they send to me via e-mail. I hereby give permission for all my present and future Crossroads counselors to reply to my messages via e-mail, including any information that they deem appropriate, that would otherwise be considered confidential. I agree that Crossroads and any employees or agents of Crossroads shall not be liable for any breach of confidentiality that may result from this use of e-mail via the internet. I understand that e-mail communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If I believe I need a response within 48 hours, I will not use e-mail but will call Crossroads Counseling and Life Coaching. If I do not receive an answer to a routine e-mail message within two working days, I understand that I should call Crossroads. I understand that all email communications may be made part of my permanent medical record and would be accessible to all current and future Crossroads counselors and staff involved in my care. I also understand that I may withdraw permission for counselors to communicate with me via e-mail by notifying my counselor in writing. (_____)

INFORMED CONSENT FOR TELEPSYCHOLOGY SERVICES

I am aware there are potential benefits and risks of telepsychology (e.g. limits to patient confidentiality) that differ from in-person sessions. There are inherent risks associated with video conferencing and the use of third party service-providers (i.e. computer IP addresses, smart phone location services, phone numbers, etc. may be retained by third party service providers). Confidentiality still applies for telepsychology services, and recording sessions is not permitted by the client or clinician.

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CLIENT INFORMED CONSENT, AGREEMENT, AND AUTHORIZATIONS, continued – Page 2 of 2

CLIENT NAME: _____ **DATE OF BIRTH:** _____

Crossroads Counseling agrees to use the video-conferencing platform selected for our virtual sessions, and the clinician or office staff will explain how to use it. I will need to use a webcam or smartphone during the session, or a telephone. It is important to be in a quiet, private space that is free of distractions (including cell phones and other devices) during the session. It is important to use a secure internet connection rather than public/free Wi-Fi. It is important to be on time. If I need to cancel or change my tele-appointment, I must notify the office sooner than 24 hours before my scheduled appointment. I will need a back-up plan (e.g., phone number where I can be reached) to restart the session or to reschedule it, in the event of technical problems. If I am not an adult, my parent or legal guardian will need to provide permission and their contact information for me to participate in telepsychology services. I should confirm with my insurance company that the video sessions will be reimbursed; if sessions not reimbursed, I am responsible for full payment. My clinician may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person once able to, until then a delay to therapy may be instilled or special arrangements may need to be made. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for purposes of conducting the healthcare operations of Crossroads Counseling & Life Coaching. I authorize Crossroads Counseling & Life Coaching to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Crossroads Counseling & Life Coaching may release the minimal necessary amount of objective clinical information related to my diagnosis and treatment which may be requested by my insurance company or its designed agent. (_____)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE

I authorize payment to be made directly to Crossroads Counseling & Life Coaching for insurance benefits payable to me. I understand that I am financially responsible to Crossroads Counseling & Life Coaching at the time of service for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and requires collection, I am responsible for the cost of collection including attorney fees and a limited amount of information about treatment will have to be shared with the attorney (i.e. treatment dates and times). (_____)

PRIVACY POLICY

I have received a copy of the clients' Notification of Privacy Practices, Clients Rights, and Responsibilities. The information was explained using language that I understand. I acknowledge I have been offered my rights with verbal explanation, including the right to see and copy my records, to limit disclosure of my health information, and to request an amendment to my record, as explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Crossroads Counseling & Life Coaching has already made disclosure with my prior consent. (_____)

_____ _____

Client's Signature Date

_____ _____

Parent/Authorized Person's Signature Date

_____

Relationship to client

_____ _____

Employee Verification Signature Date

REV 4/12/23

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