Please complete this form ONLY if you would like us to inform your Physician of your visit today.

North Coast Family Foundation

6902 Pearl Rd., Suite 502
Middleburg Heights, OH 44130
(440) 842-6867 Fax: (440) 842-8914

1660 Akron Peninsula Rd., Suite 203
Akron, OH 44313
(440) 842-6867 Fax: (440) 842-8914

Dear Dr. _____ (Primary Care Physician) Date: _____

_____ _____ _____
Address City, State Zip Code

_____ _____
Phone Number Fax Number

Your patient was recently evaluated at our office by _____. We hope the following information will be helpful for coordinating the patient's care:

Patient's Name:
Date of Initial Consultation: Date of Next Appointment:
Diagnosis/Problem:
Recommendations:

Please contact us if further information is necessary. Thank you. _____
Clinician's Signature

Patient Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, _____ hereby authorize _____ to
Print Patient's Name Print Clinician's Name

Please check one:

- o Release any applicable information to my Physician
- o Do NOT release any information to my Physician Reason: _____

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
Patient's Signature (or Guardian) Relationship to patient (if Guardian)

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FINANCIAL POLICY

PAYMENT INFORMATION

In order to provide you with the best services at the lowest possible costs, **we ask that you pay all Co-pays, Co-insurances and Deductibles prior to each counseling session.** NCFF will do everything possible to facilitate payment from your insurance company. However, please understand that **payment of any and all costs is ultimately your responsibility**, regardless of your insurance coverage. If your insurance company does not pay within 60 days of service, **you will be responsible for the remaining balance.** Most insurance companies limit the dollar amount and/or the number of sessions they will pay for each year. **You are responsible for any and all charges, should your insurance company not pay.** While we will make every attempt to keep current and accurate records of your benefits, we cannot guarantee eligibility, coverage or benefits; nor can we guarantee the accuracy of the information which your insurance company gives to us.

We bill only primary insurance, not secondary insurance. NCFF reserves the right to decline to handle any third-party payer with whom we are not contracted.

******MISSED APPOINTMENTS AND LATE CANCELLATIONS******

When an appointment is made, your counselor is reserving time for you. If you need to cancel your appointment, please call the office **at least 24 hours in advance.** ***Failure to do so will result in a $50.00 Late Cancellation Fee.*** Insurance companies do not pay for missed appointments.

DELINQUENT PAYMENT

In the event there is an outstanding balance on your account, we trust that you will pay your bill in full upon receipt of the bill. If your account becomes past due and you do not demonstrate a good faith effort to pay off the balance, we may choose to send your account to a collection agency.

FEE SCHEDULE

Licensed Psychologist: Initial Evaluation = $150.00 50 Minute Follow Up Sessions = $125.00

All Other Counselors: Initial Evaluation = $125.00 50 Minute Follow Up Sessions = $110.00

TESTING

Clients may be asked to take a standardized test for diagnostic or other purposes. There is a fee for the test and interpretation. Please be advised that many insurance companies DO NOT cover fees for testing. Please check with your insurance company to see if testing is covered under your policy.

PHONE CALLS

If you need to contact your counselor by phone, please call the office and leave a message. Phone conversations which are longer than 5 minutes will be charged at the regular hourly rate for therapy.

North Coast Family Foundation

Date:_____

Client's Name: _____ Age: _____ Sex: M F

Reason for your visit: _____

Family and Household Composition: List all immediate family and significant relationships.

Name	Relationship	Age	Where do they reside?

Marital and Relationship History

- ☐ Single/Never Married
- ☐ Married Date:_____
- ☐ Separated Date:_____
- ☐ Divorced Date:_____
- ☐ Widowed Date:_____
- ☐ 2nd Marriage Date:_____
- ☐ 2nd Divorce Date:_____
- ☐ Other:_____

Medical History

Primary Doctor: _____ Date of last physical exam: _____

List any serious illnesses, injuries or surgeries (with dates):

_____

_____

List all medications you are currently taking:

Medication	Dosage	Purpose	Side Effects	Prescribed by

Allergies: _____

Previous Treatment

List previous mental health and/or chemical dependency treatment (including alcohol or drug) you have received:

Provider/Agency	Dates	Reason	Outcome

Family History

List any medical and mental health conditions of family members:

Medical:

Family Member	Condition	Dates

Mental Health/Substance Abuse:

Family Member	Condition	Dates

Substance Use History

(Please complete if client is 12 years or older)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamine					
Cocaine					
Hallucinogens					
Others					

Legal History

Describe any pending or post-legal matters (including Visitation/Custody):

_____

_____

This information is accurate to the best of my knowledge.

_____ _____

Signature of Client Guardian (if necessary)

North Coast Family Foundation ***Patient Registration***

PATIENT INFORMATION

Patient Name _____ M F Birth Date _____ Age _____

Address _____ City _____ State _____ Zip_____

Billing Address (if different) _____

Primary Phone # _____ Secondary Phone # _____

Email Address _____

Social Security # _____ Employer _____

Marital Status: { } Single { } Married { } Separated { } Divorced { } Widowed

SPOUSE'S INFORMATION Name _____ Birth Date _____

Phone # _____ Social Security # _____ Employer _____

EMERGENCY INFORMATION In case of emergency, contact: Name _____

Relationship _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy Holder _____

Relationship to Policy Holder { } Self { } Spouse { } Child SS# _____

Policy ID # _____ Group # _____

Phone # _____

Please complete if Patient is 18 years or under: Child lives with { } Both Parents { } Mother { } Father

Mother's Name _____ Birth Date _____ Phone #_____

Address (if different) _____ City, State _____ Zip _____

Father's Name _____ Birth Date _____ Phone #_____

Address (if different) _____ City, State _____ Zip _____

PHONE CONTACT **IF WE NEED TO CONTACT YOU, **PLEASE LIST THE PHONE NUMBER** WE SHOULD USE.**

_____ CAN WE LEAVE A MESSAGE? { } Yes { } No

NORTH COAST FAMILY FOUNDATION

Practice Privacy Statement

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

I. **This is a formal notification, as required by the government concerning the privacy policy of this practice.** It is important that all patients and staff understand the importance of guarding patient information.

II. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as "PHI" or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice who we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your medical care. **You can change this information at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point in time forward.

III. Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under NCFF'S immediate care. This may include any referral for services such as diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other physicians.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include progress notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form
- Disclosure to your family and friends concerning any related health care information , which can be modified at any time orally, followed by written consent.
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity required immediate and full information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for health care oversight, such as a site review by an insurance program.
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to **avoid harm** if there is a threat to patient or other safety.
- Specific governmental functions.
- Workers compensation review.

IV. Yours rights with respect to you protected health information.

- The right to request limits on the uses and disclosure at registration or any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information, but there may be copy and postage fees.
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process if appropriate.

V. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

VI. If you have a concern or complaint about how your protected health information is being used, from this time forward you should contact our Practice Administrator at our business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights
Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
(312) 886-1807

GBA Palmetto
Part B Operations-HIPAA Compliance Concern
PO Box 18957
Columbus, OH 43218

Patient signature on receipt of Privacy Notice: _____Date:_____

Patient unable to sign due to: _____Date:_____

Patient refused to sign – witness: _____Date:_____

North Coast Family Foundation

Privacy Consent – For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to NORTH COAST FAMILY FOUNDATION to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize NORTH COAST FAMILY FOUNDATION, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health cares professional for care and treatment.

Consent for release of information for payment and operations: I also authorize NORTH COAST FAMILY FOUNDATION to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Statement: I have had a chance to review The Practice Privacy Statement as part of this registration process. I understand that the terms of the Privacy Statement may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for assignment of benefits: I consent to assign all payments for these services to NORTH COAST FAMILY FOUNDATION. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

I understand that NORTH COAST FAMILY FOUNDATION may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but NCFF may refuse further services at that time. If I revoke this consent, the revocation does not take affect until NCFF receives it.

Patient/Guardian Signature:_____ Date:_____

Name printed: _____ If not patient, relationship:_____

<u>Revocation:</u>

I hereby revoke the consent given above:

Patient/Guardian_____ Date:_____

Name printed:_____ If not patient, relationship:_____

NORTH COAST FAMILY FOUNDATION - Practice Privacy Statement

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VI.

VII. If you have a concern or complaint about how your protected health information is being used, from this time forward you should contact our Practice Administrator at our business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights
Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601
(312) 886-1807

GBA Palmetto
Part B Operations-HIPAA Compliance Concern
PO Box 18957
Columbus, OH 43218

North Coast Family Foundation

I have read and received a copy of the Financial Policy for North Coast Family Foundation.

I am aware that I will be charged $50 if I do NOT cancel my appointment at least 24 hours in advance.

I have received a copy of the Practice Privacy Statement.

I have read and signed the Privacy Consent From.

_____ _____

Patient's Signature (or Guardian) Date

_____

Patient's Name (printed)