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Mental Health Comprehensive Services

Providing Family Stability and Developing Life Coping Skills

First Name	Middle Name	Last Name

Street Address	Apt.	City	State	Zip Code

Social Security Number	Sex	Date of Birth	Marital Status

Work Phone		Email Address			
Cell Phone			Remind me of Appt. by phone only		Remind me of appt. by email
Home Phone			Remind me of appt by phone or email		Don't remind me of appt.

Employer	Employer's Address

In Case of Emergency, Notify	Phone Number

Permission to Contact

I **Authorize** MHCS to contact or leave a message pertaining to my care at the following methods contact numbers and I will assume responsibility to notify them whenever this information changes.

Preferred #1		Preferred #2	
Signature:		**Date:**	

Responsible Party/Spouse/Parent Information

Name	Social Security #

Employer	Work Phone	Date of Birth

Primary Insurance

Name of Carrier	Name if Insured

Insurance Address	Insurance Phone Number

Insured Date Of Birth	Insurance ID#	Insurance Group #

Secondary Insurance

Name of Carrier	Name if Insured

Insurance Address	Insurance Phone Number

Insured Date of Birth	Insurance ID#	Insurance Group #

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of Medical/Psychiatric benefits directly to MHCS. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Client/Legal Guardian Signature:	Date
X	

Revised: 1/13; 7/14, 1/17 Reviewed: 2/14

Last Name	First Name	Date of Birth

Permission for Treatment			
I grant permission to Mental Health Comprehensive Services to provide mental health services to me and /or my child. I understand that as a part of my treatment, I may have to complete lab work and/or other procedures related to my care. I agree to participate in treatment and I understand that I am ultimately financially responsible for the care provided.			
Client/Legal Guardian Signature:	x	Date:	
Cancellation and Missed Appointments			
Individuals have a responsibility to notify MHCS of the need to cancel, miss or reschedule an appointment because of illness or an emergency. This must be done at least 24 hours of the appointment. Failure to provide such notification will result in a $75 payment for missed therapist appointment, $150 initial psychiatric Assessment, and $85 for psychiatrist visit.			
Client/Legal Guardian Signature:	x	Date:	
Non-sufficient Fund Fee			
It is the policy of MHCS to charge a $35 insufficient fund fee for any returned checks and/or denied or rejected credit card transaction. This fee and the balance of the original charges are due immediately upon notification and will be collected before any further services are rendered.			
Client/Legal Guardian Signature:	x	Date:	
Insured's or Authorized Person Signature			
I Authorize the Release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below. I further authorize payment of medical benefits to Mental Health Comprehensive Services, LLC and its agent or supplier for the services rendered to myself or dependent.			
Client/Legal Guardian Signature:	x	Date:	
Permission to Photograph			
I authorize MHCS to take my picture which will become a part of my paper and electronic chart information. I understand that this picture will also be used to identify me as the person seeking service. I also understand that the picture will remain a part of the record until the records are eligible to be destroyed in accordance with state and federal guidelines.			
Client/Legal Guardian Signature:	x	Date:	
Administrative Fees			
It is the policy of MHCS to charge for completing paperwork outside of the normal required insurance. As it requires additional time and resources, it is necessary for this office to charge. Listed below are the fees for completing additional paperwork and services: Court Appearance cost is not paid for by insurance and is the responsibility of the individual. The cost of a Clinician attending court is $300/hr. with a minimum cost of $600 for the actual appearance. Court Preparation cost is at $150/hr. **Disability/FMLA Paperwork is $65** | **Updates on Disability/FMLA paperwork is $35** | **Copying Charts: See Staff for Cost** *If Disability paperwork is requested by SSA or an Attorney, we will follow the standards set by law, which is then billed to the requestor.* ❖ *Other administrative services that are not a covered service/benefit under your certificate of insurance. The fee will be determined at the time of request.* ❖ *All of these activities add to the cost of caring for the clients. Still, we are committed to providing you with quality care.*			
Client/Legal Guardian Signature:	x	Date:	

Revised: 1/13;11/15, 1/17 Reviewed 2/14, 10/14

Last Name	First Name	Date of Birth

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Thank you for choosing Mental Health Comprehensive Services, our therapist and psychiatrist as your behavioral/mental health providers. We are committed to providing you the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our patient information form prior to seeing the physician. Payments for services are due at the time services are rendered. We accept cash, check, credit cards Visa, Discover and MasterCard. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of benefits. However, you must understand that:

1. Your insurance policy is a contract between you, and your employer and the insurance company. Our relationship is with you. We cannot be involved in disputes between you and your insurer regarding deductibles, copayments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We follow their guidelines for reimbursements and submission of claims for services rendered. Any contractual provider discount will be deducted from you balance.
2. All charges are your responsibility-whether you're insurance company pays or does not pay. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and copayments, are due at beginning of treatment.
4. If you have a high deductible health plan, we will collect payment at time of visit.
5. If you insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all if your insurance does not pay you are responsible for payment.
6. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you I the management of your account.
7. It is your responsibility as the patient to give us any updated information regarding insurance/ address/ or phone number changes.

Client Signature and/or Parent/Guardian	Date
X	
Witness Signature	**Date**

Revised: 1/13;11/15, 1/17 Reviewed 2/14, 10/14

Last Name	First Name	Date of Birth

HIPAA/Privacy Statement

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MENTAL HEALTH INFORMATION MAINTAINED BY *MENTAL HEALTH COMPREHENSIVE SERVICES, LLC* (MHCS) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

MHCS may *use* or *disclose* your *protected health information* (*PHI),* for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *PHI* refers to information in your health/counseling record that could identify you.
- *Treatment, Payment and Health Care Operations*
  - *Treatment* is when MHCS provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your counselor consults with another health care provider, such as your family physician or another mental health service provider.
  - *Payment* is when MHCS obtains reimbursement for your healthcare. Examples of payment are when MHCS discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of MHCS. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *Disclosure* applies releasing your mental health information to other parties.

II. Uses and Disclosures Requiring Authorization

MHCS may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *authorization* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when MHCS is asked for information for purposes outside of treatment, payment and health care operations, MHCS will obtain an authorization from you before releasing this information. MHCS will also need to obtain an authorization before releasing your psychotherapy notes. *Psychotherapy notes* are notes that your counselor has made about conversations and/or activities during a private, group, joint, or family counseling session, which are kept separate from the rest of your counseling record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) MHCS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

MHCS may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If a child receives counseling services at MHCS, who appears to be the victim of physical or sexual abuse, MHCS must report such to the nearest law enforcement agency.
- **Adult and Domestic Abuse:** If MHCS has reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect or exploitation, MHCS is required by law to make a report to either the State of Georgia Department of Human Services, the district attorney's office, or the municipal police department as soon as MHCS becomes aware of the situation.
  - A vulnerable adult means an individual who is an incapacitated person or who, because of physical or mental disability, incapability, or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him or herself, or is unable to manage his or her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him or herself from abuse, neglect, or exploitation without assistance from others.
- **Health Oversight:** If you file a disciplinary complaint against a MHCS counselor with the Georgia State Board of Examiners of Psychologists (for psychologists) or the State of Georgia Department of Health (for licensed professional counselors), they would have the right to view your relevant confidential information as part of the proceedings.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
  - If any member of the Agency's staff is required to attend count at your or your lawyer's request, there will be a standard/hour fee billed to you for preparation time and any time spent in court.
- **Serious Threat to Health or Safety:** If you communicate to a MHCS counselor an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, MHCS has the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others.

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MHCS also has such a duty if you have a history of physical violence of which MHCS is aware, and SCS has reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.

- **Workers Compensation:** If you file a workers compensation claim, you will be giving permission for the Administrator of the Workers Compensation Court, the Georgia Insurance Commissioner, the Attorney General, a district attorney (or a designee for any of these) to examine your records relating to the claim.

IV. Patient's Rights and Agency's Duties

Patients Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, MHCS is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a counselor at MHCS. Upon your request, MHCS will send your bills to another address.)
- *Right to Inspect and Copy* You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. MHCS may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, MHCS will discuss with you the details of the request and denial process.
- *Right to Amend* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. MHCS may deny your request. On your request, MHCS will discuss with you the details of the amendment process.
- *Right to an Accounting* You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, MHCS will discuss with you the details of the accounting process.
- *Right to a Paper Copy* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

MHCS Licensed Professional Counselors Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will . . . [*Notice must also describe how the psychologist will provide individuals with a revised notice, e.g., by mail.*]

Georgia and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how OUR PRACTICE may disclose information about you to others.

Confidentiality - HIV Antibody/AIDS Status

a.) The confidentiality of the following information is protected by the AIDS Act and AIDS Code:

1) The identity of a person upon whom a test for HIV is performed; and
2) The results of a test for HIV for an individual.

b.) An HIV antibody or AIDS test cannot be required as a condition of treatment, and an individual cannot be required to disclose or to sign an authorization for release of information concerning his or her HIV antibody test or HIV or AIDS status as a condition of treatment.

c.) Unless disclosure is otherwise authorized by statute and rule, no information governed by the AIDS Confidentiality Act and the AIDS Code shall be released by an organization, or by any member of its staff, to other staff members, including but not limited to the executive director, and/or to the medical director, and/or to any other person or entity, unless there is a legally effective consent or another exception in accordance with the statute and rule. Release of information which is allowed by consent or by statute and rule shall be done only to the extent provided therein.

d.) Records which document the above confidential information shall be maintained in a separate portion of the file and be accessible only in accordance with the AIDS Confidentiality Act and Section 697.140(c) of the AIDS Code.

e.) The organization shall have a policy regarding how and what shall be recorded if a person self-discloses HIV status during the course of treatment or if the person requires the administration of medications or other services by staff related to AIDS treatment. The policy shall protect the confidentiality of the person and protect his or her right to give consent prior to disclosure of HIV status, and shall limit disclosure to only what is necessary to accomplish the purpose of the disclosure.

Client Signature and/or Parent/Guardian		Date	
Witness Signature		Date	

Revised: 1/13;11/15, 1/17 Reviewed 2/14, 10/14

Last Name	First Name	Date of Birth

Client Rights

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;
2. The right to service in a respectful setting that offers the greatest possible freedom as defined in the treatment plan;
3. The right to be kept up-to-date on current or suggested services, treatment or therapies, and of alternatives;
4. The right to accept or reject any service, treatment or therapy after you have been given a full explanation of the risks and benefits;
5. The right to a current, written, individualized service plan addressing mental and physical health, social and financial needs, and describing who will provide these services and how they will be provided in a way that meets your needs;
6. The right to active and informed participation in all areas of the service plan, including the plan's writing, review, and rewriting to meet your needs;
7. The right to freedom from too much or unnecessary medication;
8. The right to freedom from restraints or seclusion;
9. The right to be informed of and to refuse any unusual or dangerous treatment procedures;
10. The right to be told about and to refuse to be observed through one-way mirrors, photographed or taped (audio or visual);
11. The right to absolute confidentiality unless court ordered or if you sign a Release of Information form permitting disclosure of all or part of your record;
12. The right to see *all* parts of your records, including psychiatric and medical records. Access can be restricted *only* for clear treatment reasons, meaning that reading the records will cause you severe emotional damage resulting in the immediate risk of dangerous behavior toward yourself or someone else. Only specific parts of the chart can be restricted, with the reasons clearly documented in your service plan. However, you may give permission to *any person you choose* (friend, family member, advocate) to look at *all* parts of your record;
13. The right to advance notice if a service is to be discontinued, and to be actively involved in planning to meet your needs when the service is discontinued;
14. The right to have a clear explanation when any services are denied;
15. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay;
16. The right to be fully informed of all rights;
17. The right to exercise any and all rights without being threatened or punished in any way, including being denied services.

A full copy of your consumer rights is available to you on report. A summary of the Consumer Rights Compliant Process is also available.

The Consumer/ legal Guardian has had an opportunity to read, or have read to him/her, the above form and ask questions regarding the data contained therein and have in this staff member's presence.

Client Signature and/or Parent/Guardian	Date
Witness Signature	**Date**

Revised: 1/13;11/15, 1/17 Reviewed 2/14, 10/14

Last Name	First Name	Date of Birth

Grievance and Complaint Form

The consumer will be encouraged to bring concerns, suggestions and problems with his/her individual treatment and the staff with his/her provider. The consumer will follow an appeals process when discussion does not resolve the issue from the client's perspective.

Procedure:

The consumer may request to speak with the Client Rights Advocate. The Client Rights Advocate will contact a client within 48 hours of the discussion to resolve the issue. If the issue is not resolved, the consumer must submit a written complaint and may ask for a meeting with the Quality Improvement Manager.

The Quality Improvement Manager will meet with the consumer within three (3) days to discuss the problem and to negotiate a mutually acceptable solution. If the consumer is not satisfied with the response the next step is to be taken.

The consumer may request a meeting with the CEO within 48 hours of meeting with the Quality Improvement Manager. The CEO will meet with the consumer within five (5) days to discuss the problem and to negotiate a solution.
The CEO will respond to the consumer in writing explaining the outcome of the appeal within seven (7) days from the time of their meeting.
If a consumer is dissatisfied with the decision by the CEO, the grievance is then filed with the appropriate DBHDD official with ten (10) days. The DBHDD official, within fourteen (14) days, will provide a final decision.

Address for filing complaint to DBHDD:
Division of DBHDD
Attn: Gwen Craddieth
3073 Panthersville Rd.
Building 10
Decatur, GA 30034
Phone: (404) 244-5050 and (404) 244-5056
Fax: (404) 244-5179

Client Signature		**Date**	
Legal Guardian Signature		**Date**	
Witness Signature		**Date**	

Revised: 1/13;11/15, 1/17 Reviewed 2/14, 10/14

Last Name	First Name	Date of Birth

"JUST IN TIME DOC" ACCESS POLICY

As of January 2015, Mental Health Comprehensive Service began a new process/procedure to schedule an appointment to see the Psychiatrist. The process is called Just in Time Doc. Just in Time Doc means that doctor's appointments will be scheduled 3 to 5 business days ahead.

How does this Policy Impact your ability to see the Psychiatrist?

Over the past few years, there was a 40-55% no show rate for psychiatrist appointments, while we had other clients waiting to see the doctor. We have found it necessary to change our scheduling policy to one that allows open, flexible and client friendly access to the psychiatrists.

How do I get an appointment to see the Psychiatrist?

The front desk staff will give you a reminder card when you leave your doctor's appointment instead of scheduling a follow-up appointment. The reminder card will let you know when the week to call into the MHCS office to schedule your next appointment. When you call, your appointment will be scheduled within 3 to 5 business days.

What if this is my first time seeing the Psychiatrist?

Upon leaving your therapy session, if it is determined by the counselor (in conjunction with you as the client), an appointment for the psychiatrist will be schedule 3-5 business days from that encounter. If it is not convenient for you to see the psychiatrist during that time frame, you will be given a card with the week you should call back to schedule an intake appointment with the Psychiatrist.

What if I No Show or Cancel Late for the Scheduled Psychiatrist Appointment?

If you do not cancel your appointment within 48 hours of your appointment, a $75 late cancellation fee will be assessed to you. If you No Show or Cancel 2 consecutive times, you will be seen through our walk-in clinic. Walk-in Clinic days and times are available at the Front Desk.

The MHCS Open Access policy has been explained to me and I understand the following:

- No psychiatrist appointment will be made past 5 business days.
- You will be given a card that states to call 1 week before your needed appointment to schedule with the psychiatrist.
- MHCS will no longer call in medication refills into the pharmacy if I miss my appointment. Medication will be filled for clients who have been seen face to face by the doctor.

Client Printed Name	Client/Guardian Signature	Date
Staff Signature		**Date**

Revised: 1/13;11/15, 1/17 Reviewed 2/14, 10/14