TRAUMA TREATMENT CENTER
& Research Facility

# Adult Services Intake

Date: _____

How did you hear about us? _____

**PATIENT INFORMATION**

First Name: _____ MI: _____ Last Name: _____

Home Address (City, State, Zip): _____

Mailing Address (City, State, Zip): _____

Home Phone #: _____ Cell #: _____

Email Address: _____

DOB: _____ SS #: _____ Gender Identity:_____

□ Married □ Single □ Other

Occupation: _____ Employer: _____

Employer Address (City, State, Zip): _____

Employer Phone #: _____ Contact: _____

Emergency Contact: _____ Relationship: _____

Home Phone #: _____Cell Phone #:_____

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## INSURANCE INFORMATION

Primary Insurance Information

Insurance Carrier: _____
Address: _____ Phone: _____
Member ID#: _____ Group #:_____

Secondary Insurance Information (If Applicable)

Insurance Carrier: _____
Address: _____ Phone: _____
Member ID#: _____ Group #:_____

Tertiary Insurance Information (If Applicable)

Insurance Carrier: _____
Address: _____ Phone: _____
Member ID#: _____ Group #:_____

Guarantor Information (Financially Responsible Party)

First Name: _____ MI: _____ Last Name:_____
Mailing Address (City, State, Zip): _____
Home Phone #: _____ Work Phone #: _____
Relationship to Patient: _____ DOB: _____
SS#: _____ Gender Identity: _____
□ Single □Married □Other
Drivers License #: _____ State Issued: _____ Expiration Date: _____
Employer : _____
Address (city, State, Zip): _____
Occupation: _____ Phone #: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company(s) listed above and assign directly to Trauma Treatment Center all insurance benefits if any, otherwise payable to me for services rendered. I hereby certify the above information to be true and correct to the best of my knowledge. I hereby authorize Trauma Treatment Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient: _____ Date: _____

Signature of Guarantor: _____ Relationship: _____

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## PATIENT FINANCIAL RESPONSIBILITY

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you; however, the patient is required to provide the most accurate and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance and/or deductibles due at the time of service. In the event that the patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agrees to pay the costs of all services provided.
- If the patient is uninsured, the patient agrees to pay for the medical services rendered at the time of service.
- If a patient's insurance plan requires a referral, they must obtain one prior to making their appointment.
- Patients may incur and are responsible for payment of additional charges if applicable.

By my signature below, I hereby authorize assignment of financial benefits directly to Trauma Treatment Center. I understand that I am financially responsible for charges not covered by this agreement.

**I have read, understand, and agree to the provisions of the Patient Financial Responsibility form.**

Signature of Guarantor: _____ Date:_____

Signature of Therapist: _____ Date:_____

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**Mental Health Advanced Directive**

Would you like to complete a Mental Health Advanced Directive for this patient?

□ Yes: You will be given an additional packet to complete prior to intake.

□ No: Signature of Patient: _____ Date: _____

**Mental Health Photo Consent**

I give consent to Trauma Treatment Center to take a current photo of me. I consent that the photo may be taken by an authorized Trauma Treatment Center staff member and used for the sole purpose of positive identification and placed in my Electronic Health Record (EHR).

Signature of Patient: _____ Date: _____

□ Refusal to Consent to Photo

Signature of Patient: _____ Date: _____

**Acknowledgments** (Please Initial)

I have read, understand and been offered a copy of the Policy Statement _____

I have read, understand and been offered a copy of the Client's Rights _____

I have read, understand and been offered a copy of the Client's Responsibilities _____

I have read, understand and been offered a copy of the Billing Policy _____

I have read, understand and been offered a copy of the HIPPA Information _____

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## OUTSIDE PROVIDER NOTIFICATION

Patient Name: _____ Date of Birth: _____

****Release of information to your Provider is not a condition of service.** If you want your provider notified that you are receiving counseling because it is relevant to your condition, please provide their name, address and phone/fax number. This is the exact form and information that will be sent to them. In this case, information must be provided and complete.

□ **YES,** I want Trauma Treatment Center to release information to my rovider regarding treatment for coordination of care.

□ **NO, I DO NOT** want Trauma Treatment Center to release information to my Provider regarding treatment for coordination of care.

Signature of Patient: _____ Date: _____
Signature of Guardian: _____ Date: _____

Provider's Name: _____
Address (City, State, Zip): _____
Phone #:_____ Fax#: _____

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For office use only

Dear Provider:
This letter is to inform you that Trauma Treatment Center is providing services for the above named patient. The following is a brief treatment report regarding this patient. Please contact us should you have any questions or desire further information.

Presenting Problems:_____
Diagnostic Impression: _____
Summary of Treatment Plan/Services: Please see attached
Current Medication: _____
Estimated Date of Discharge: _____

□ No information is requested from your office at this time

□ Information is requested as detailed on the authorization for Release of Information

□ We are referring this patient to you for: _____

Signature of Therapist: _____ Date: _____

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## TREATMENT AGREEMENT

This agreement contains terms concerning the patient's request for voluntary treatment and provides Trauma Treatment Center with consent to render treatment. The terms of this agreement are binding on the patient, so the document should be read carefully. You are encouraged to ask questions you might have concerning the terms of this contract.

I authorize Trauma Treatment Center, through its employees, to provide such services and treatment as necessary. I understand that some of Trauma Treatment Centers' clinicians are not credentialed with every insurance company and are not all independently licensed clinicians. All of the clinicians are licensed in the state of New Mexico, at either 1st or 2nd level of licensure. If a clinician is not credentialed with a specific insurance provider the session may be billed under the supervisor's license for reimbursement purposes, as this is an acceptable arrangement between the agency and the multiple insurance providers to seek reimbursement under services rendered. All clinicians practice therapy under the supervision of an independently licensed therapist. Sometimes this supervision may take the form of live supervision (individually or as a group) or by reviewing sessions that have been video tapped (with patient consent). At times supervision may be video tapped to also be reviewed within supervision for the supervisor.

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a patient in psychotherapy, you have certain rights that are important for you to know about because this is your therapy. There are also certain limitations to those rights that you should be aware of.

### Our Responsibility as Your Mental Health Treatment Provider

#### I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy Trauma Treatment Center cannot and will not tell anyone else what you have told your clinician, or even that you are in therapy with Trauma Treatment Center without your prior written permission. Trauma Treatment Center will always act so as to protect your privacy even if you do release Trauma Treatment Center in writing to share information about you. You may direct Trauma Treatment Center to share information with whomever you chose, and you can change your mind and revoke the permission at any time.

In many cases Trauma Treatment Center clinicians see multiple members of the same family. It is pertinent in the treatment process of this family for the clinician to coordinate care and develop treatment plans together with the family members. Interagency treatment coordination between clinicians is necessary to provide optimal treatment for the whole family.

All Trauma Treatment Center clinicians are engaged in weekly or bi-weekly supervision with a member of the supervisory team. Patient information may be discussed with any member of the supervisory team to support ethical and effective treatment of the patient.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Whenever Trauma Treatment Center transmits information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with your clinician by email at some point in your work together, please be aware that email is not completely confidential. Any email Trauma Treatment Center receives from you, and any response that we may send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. The clinician will inform the patient when the clinician will have to put these into effect.

1. If the clinician has good reason to believe that you will harm another person, the clinician must attempt to inform that person and warn them of your intentions. The clinician will also contact the police and ask them to protect your intended victim.
2. If the clinician has good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give the clinician information about someone else who is doing this, the clinician must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If the clinician believes that you are in imminent danger of harming yourself, the clinician may legally break confidentiality and call the police. The clinician is not obligated to do this and would explore all other options with you before they take this step. If at that point you are unwilling to take steps to guarantee your safety, the clinician would then call the police.
4. Adults and children receiving psychological services should know that New Mexico law protects children as well as adults form the unauthorized disclosure of confidential information. Guardians of children receiving psychological services should know that New Mexico Law permits children 14 years of age and

older the right to consent to treatment, the right to disclose medical and mental health records, and the right to have control over access to their medical and mental health records.

## II. Record Keeping

Trauma Treatment Center keeps very brief records, noting only that you have been here, what interventions happened in session, and the topics discussed. You have the right to request that we make a treatment summary available to any other health care provider at your written request. Your records remain in a secure electronic location that cannot be accessed by anyone else.

## III. Diagnosis

If a third party such as an insurance company is paying for any part of your bill, the clinician is normally required to give a diagnosis to that third-party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If we do use a diagnosis, we will discuss it with you. All of the diagnoses come from the DSM-V.

## IV. Other rights

You have the right to ask questions about anything that happens in therapy. Trauma Treatment Center clinicians are always willing to discuss how and why your clinician has decided to do what they are doing, and to look at alternatives that might work better. You can ask the clinician about their training for working with your concerns and can request that they refer you to an alternate clinician if you decide they are not the right clinician for you. You are free to leave therapy at any time.

## V. Managed Mental Health Care

If your therapy is being paid for in full or part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decisions to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with your clinician, or to require you to use medication if their reviewing professional determines it appropriate. They may also decide that you must see another clinician in their network rather than your current clinician. Such firms also at times will require some sort of detailed reports of your progress in therapy. Trauma Treatment Center does not have control over any aspect of their rules. However, we will do all that we can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment and assist you in advocating with the managed care company as needed.

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**Your responsibilities as the Therapy Patient**

Our standard fee for an initial intake session is $150.00 and for each session thereafter is $75.00 group sessions are $25.00 each (all payable at the beginning of each session). We are a provider for multiple insurances and all insurance billing will go through Therapy Notes. Co-pays/deductibles/co-insurances can be made by cash and/or debit/credit cards. Please inform the Office Manager or Clinical Director if any problems arise during the course of therapy affecting your ability to make timely payments. Any services provided such as report writing, phone consultations, or phone sessions that last longer than 15 minutes are billed to you directly.

Sessions last for 26-55 minutes. If you are late, we will end on time and not run over into the next person's session. If your clinician is running behind, you will receive the entire time of your scheduled session. If you cancel without 24 hour's notice, you will be charged a $50.00 fee. The exceptions to this rule would be cancellations due to sickness or events out of your control.

If you have insurance, you are responsible for providing Trauma Treatment Center with the information we need to send in your bill. We handle our billing within Trauma Treatment Center, billing questions may be directed to our Office Manager at (505) 289-1042.

You are expected to maintain civil and respectful behaviors, your behaviors may not violate the New Mexico State Criminal Statues, especially as they relate to harm to self or the person or property of others. In order to promote the successful resolution of the reasons you have come into therapy, you will be expected to work towards mutually agreed upon goals.

You are expected to provide any and all relevant documentation related to custody and/or court proceedings prior to your first scheduled appointment.

If you should arrive for your scheduled appointment under the influence of any mind-altering chemical, you will be asked to reschedule for another time.

For liability reasons, children under the age of fourteen may not wait in the waiting room unaccompanied unless pre-arraigned by the clinician and guardian. Therefore, the child cannot be dropped off by the guardian and cannot be left unaccompanied in the office. Child must also be accompanied to the restroom as they are for public use of the entire building. Caregiver(s) may be asked to check in with the clinician separately from the child. It is the caregiver(s) responsibility to notify the clinician if the caregiver(s) does not feel safe to leave the child(red) unattended in the lobby during this time. Caregiver(s) are expected to make other arraignments for supervision of the child(ren)

or to make other arrangements to meet with the clinician separately, if no supervision is available or if the caregiver(s) feels the child(ren) cannot engage in safe behaviors while unattended.

**Complaints**

If you are unhappy with what is happening in therapy, we hope you will talk about it with your clinician so that we can respond to your concerns. We will take such criticism seriously and with care and respect. If you believe that we have been unwilling to listen and respond, or that we have behaved unethically, you can file a complaint to the New Mexico Counseling and Social Work Licensing Board.

Signature of Patient: _____ Date: _____

Signature of Therapist: _____ Date: _____

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## RECORDS REQUEST POLICY

Trauma Treatment Center keeps very brief records, noting only that you have been here, what interventions happened in session, and the topics discussed. You have the right to request that we make a copy of your file available to any other health care provider at your written request. Your records remain in a secure location that cannot be accessed by anyone else.

*Does a parent/guardian have the right to receive a copy of psychotherapy notes about a patient's mental health treatment?*

No. The HIPPA Privacy Rule distinguishes between mental health information in a mental health professional's private notes and that contained in the medical record. It does not provide a right of access to psychotherapy notes, which the HIPPA Privacy Rule defines as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. See 45 CFR 164.501. Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes. Thus, the HIPPA Privacy Rule includes an exception to an individual's (or personal representative's) right of access for psychotherapy notes. See 45 CFR 164.524(a)(1)(i).

However, parents/guardians generally are the personal representatives of the minor patient and, as such, are able to receive a copy of the patient's mental health information contained in the medical record, including information about diagnosis, symptoms, treatment plans, etc. Further, although the HIPPA Privacy Rule does not provide a right for a patient or personal representative to access psychotherapy notes regarding the patient, HIPPA generally gives providers discretion to disclose the individual's own protected health information (including psychotherapy notes) directly to the individual or the individual's personal representative. As any such disclosure is purely permissive under the HIPPA Privacy Rule, mental health providers should consult applicable State law for any prohibitions or conditions before making such disclosures.

Trauma Treatment Center's policy is to not disclose any psychotherapy notes without the express written consent of the patient and/or personal representative and to that end will only disclose records to other providers for continuity of care. All requests for records must be submitted in writing and will be processed within 30 days of the request. Trauma Treatment Center does charge a $30.00 fee for all records requested.

Signature of Patient: _____ Date: _____

Signature of Therapist: _____ Date: _____

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## CREDIT CARD AUTHORIZATION

We have implemented a policy which enables us to maintain your credit card information securely on file. In providing us with your credit card information, you are giving Trauma Treatment Center permission to automatically charge your credit card on file for your co-pay, deductible, or co-insurance at the time of service. By signing this, you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this at any time by submitting a written request.

Co-pays/deductibles/co-insurance: Are all due at the time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, Trauma Treatment Center will notify you via phone, in person, or through a client statement. If by the final billing after discharge notice we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent via mail to you at the address we have on file. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I authorize Trauma Treatment Center to charge co-pays/deductibles/co-insurances and outstanding balances on my account to the following credit card:

□ VISA □ Master Card □ American Express □ Discover

Credit Card Holder's Name: _____

Credit Card Number: _____

CVV: _____ Expiration Date: _____

Billing Address (City, State, Zip): _____

Card Holder's Signature: _____ Date: _____

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**CANCELLATION AND MISSED APPOINTMENT POLICY**
IMPLEMENTATION DATE 2/1/19

A cancellation made with less than 24-hour notice significantly limits our ability to make the appointment available for another patient in need. Multiple cancellations in a month significantly limits out ability to provide adequate treatment to your child/family.

To remain consistent with our mission, we have instituted the following policy:

- Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left on our voicemail to avoid a cancellation fee being charged.
- A "No-Show" or "No-Call" or missed appointment, without proper 24-hour notification, may accrue a $50 fee.
- This fee is not billable to your insurance.
- After one "No-Show", "No-Call" or cancellation within 24-hours, your therapist will be in communication with you that week. After a second "No-Show", or cancellation within 24 hours, you may lose your regularly scheduled appointment time.
- After 2 "No-Show", "No-Call" or cancellation within 24-hour appointments within a 30-day period you may lose your regularly scheduled appointment time.
- After 3 "No-Show", "No-Call" or cancellation within 24-hour appointments, you will be referred to another mental health provider for services.

If you have any questions regarding this policy, please let out staff know, and we will gladly clarify any questions you have. A copy of this policy will be provided to you if you need.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time to time by Trauma Treatment Center.

Signature of Patient: _____ Date: _____

Therapist Signature: _____ Date: _____

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## COORDINATION OF BENEFITS

What is coordination of benefits?

Coordination of Benefits (COB) is a process where individuals, couples or families who are covered under more than one health plan combine their coverage to maximize their benefits. One plan becomes the primary plan and pays benefits first while the other plan becomes the secondary plan and pays the remaining balance for eligible expenses. It is crucial that a COB is set up to avoid rejected claims, and ultimately, the patient becoming responsible for any and all charges for services. Ultimately, both insurances need to be aware of each other, and need to know who the primary and secondary provider/payer is. You and your insurance companies are responsible for deciding what provider is primary and what provider is secondary.

Examples of COB include:

Children covered under both guardians' plan (i.e. Medicaid and another commercial company's health plan)

Children covered under both guardians' plan (i.e. A BCBS commercial plan and a Presbyterian commercial health plan)

It is our policy to obtain proof of COB before scheduling a potential patient with dual insurance coverage. We must be provided a contact name and a reference #/ticket # regarding the conversation you have had with BOTH of the insurance providers around setting up a COB, this way we can contact both companies to verify that they know who the primary and secondary payers are. When all of this information is provided, we can in turn properly bill both providers and avoid a disruption of services due to lack of payment.

If a patient at Trauma Treatment Center obtains dual coverage after becoming an established patient, the responsible parties will have 14 days to provide proof of a COB or services may be suspended.

Signature of Patient: _____ Date: _____

Signature of Therapist: _____ Date: _____

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## CONSENT FOR EMAIL AND /OR TEXT MESSAGE COMMUNICATION

Email and Text messaging allows Trauma Treatment Center providers to exchange information efficiently for the benefit or our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or transmission.

□ Yes, I authorize Trauma Treatment Center to send me emails and/or text messages that may contain my private health information in them.

Email: _____ Phone #: _____
Email: _____ Phone #: _____
Email: _____ Phone #: _____

□ No, I do not want to receive emails or text messages that may contain my private health information. Please only use U.S. Mail or telephone to communicate with me.

Trauma Treatment Center utilizes an automated system to send appointment reminders via test messaging.

□Yes, I consent to receive text messages for appointment reminders.

Phone #: _____
Phone #: _____
Phone #: _____

□No, I would prefer my appointment reminders to be sent:

□ Via Email: _____
□ Via Phone Call: _____

Signature of Patient: _____ Date: _____

Signature of Therapist: _____ Date: _____

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**INFORMED CONSENT FOR TREATMENT**

I give consent for evaluation and treatment to be provided to me by _____.
Therapist Name

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to the therapist so that I will receive effective treatment. I also agree to play an active role in the treatment process.

I understand that I may terminate at any time.

My signature below shows that I understand and agree with all of the above statements.

Signature of Patient: _____ Date: _____

Patient Printed Name: _____

Signature of Therapist: _____ Date: _____