Melody Mitchell, LCSW

Intake Agreement

What to expect:

Psychotherapy is difficult to define. Each therapist has their own methods used to promote wellness and healing. Each therapist is different, and each client has their own set of different characteristics and experiences as well. Therapy is an active process that often requires hard work and discomfort on those seeking change. Negative feelings may come up during the course of this process. Often times change and developing new ways to navigate relationships or circumstances can feel worse before feeling better. Communication is an important part of the therapeutic relationship. Please let me know if something is not working for you or if you need something different altogether. The goal is to help you, so please let me know how your feelings are developing as our process moves forward.

Payment:

My fee for a 55 minute session is $125. Many clients use a third party payer for services such as an insurance company. It is important for you to know that you are ultimately responsible for pay your therapy fees. If your insurance provider fails to pay for a service you will be expected to pay your outstanding balance. Additionally, your copay is due at the time of service. Your insurance company does not pay for cancelations or no shows. Please cancel your appointment at least 24 hours in advance to avoid a fee. The fee for cancelations without 24 hours' notice and no-shows is $125. Three missed appointments or cancelations will result in a discharge from services.

Emergencies:

I am not available to provide emergency services. I will respond to calls, texts, or emails in 24-48 hours. If you have an emergency you will need to call 911.

Privacy and Confidentiality:

Everything discussed during our therapy sessions is private and confidential. Confidentiality is broken under the following circumstances:

1) You are a danger to yourself or someone else.
2) You sign a release of information and ask me to disclose private information.
3) I am court ordered to disclose information.

It is important to maintain the integrity of the therapeutic relationship in a professional manner. I do not engage in social relationships with clients outside of the office or on any social media sites. If I see you in the community I will not approach you or acknowledge the nature of our relationship unless you first choose to do this.

_____ I understand the description of services and policies outlined above.

_____ I consent to treatment with Melody Mitchell, LCSW.

_____ I give permission to Melody Mitchell, LCSW to text, call, or email me concerning appointments or to share relevant information and I am aware that these communications are not encrypted.

Client Signature:_____Date:_____

Melody Mitchell, LCSW

Registration Form

Name:_____Date of Birth:_____

Address:_____ City:_____Zip:_____

Phone:_____Is it okay to leave you a message? YES NO

Email:_____

Credit Card Number:_____Expiration:_____CCV:_____

Insurance Billing and Information

Policy Holder Name:_____

Policy Holder Date of Birth:_____

Policy Holder Employer Name:_____

Name of Insurance Company:_____

Insurance Group Number:_____

Insurance Member Number:_____

Assignment of Benefits

I have insurance with _____. I assign directly to Melody Mitchell, LCSW all medical/behavioral health benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance, except where this is explicitly disallowed by the terms of the contract between Melody Mitchell, LCSW and the insurer. I authorize Melody Mitchell, LCSW to release all information necessary to secure benefit payments. I authorize the use of this signature on all insurance submissions related to care provided by Melody Mitchell, LCSW.

Client Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES

This document outlines how your medical information may be used and disclosed. It also outlines how you can obtain access to this information. Please review this document carefully. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable information used or disclosed by this provider in any form, paper, electronically, or verbally be kept properly confidential. This act gives you, the client, significant new rights to understand and control how your health information is used. There will be a record kept of the healthcare that you receive in order to provide you with quality care and to comply with legal requirements.

This notice will provide information about the way that your healthcare information may be used or disclosed. It will also describe your rights and my obligations regarding the use and disclosure of your healthcare information.

I am required by law to:
Keep private healthcare information that identifies you;
Give you this notice of legal duties and privacy practices with respect to healthcare information about you, and
Follow the terms of the notice that is currently in effect.

Outlined below are the different purposes for which your information may be used or disclosed.

Treatment: Providing, coordinating or managing healthcare and related services by one or more mental health providers.

Payment: Use and disclosure of health information so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or from a third party payer.

Healthcare Operations: For the business aspects of running a practice, such as utilization reviews, auditing functions and customer service. Individuals involved in your care or payment for your care. Information may be released to a friend or family member who you identify and who is involved in your healthcare. Information may also be given to someone who pays for your care. As required by law. Information will be disclosed as required by federal, state, or local law. You have the following rights regarding healthcare information maintained about you:

Right to Inspect and Copy: To do so, please submit your request in writing. You will be charged a fee for any costs incurred in copying and/or mailing your request. In some instances, the North Carolina Mental Health and Developmental Disabilities Confidentiality Act, the HIV/AIDS and STD laws require your written permission before releasing information.

Right to Amend: Any information that you feel is incorrect or incomplete. To do so, please submit your request in writing. Your request may be denied if you ask to amend information that was not created by me, not part of the information kept by me, is not part of the information which you would be permitted to copy or inspect, or is already accurate and complete.

Right to an accounting of disclosures: To request an accounting of non-routine disclosures, submit your request in writing with a time period. You will be charged a fee for any costs involved in obtaining. Reproducing and mailing the report.

Right to request restrictions: You may request a restriction or limitation be placed on the healthcare operations. You also have the right to restrict the information disclosed about you to someone who is involved in your care or involved with the payment for your care, such as a family member or friend. Your request must be in writing and must include the information you want to limit, whether you want to limit use, disclosure or both, and to whom you want the limits to apply.

Other uses of Healthcare Information: Other uses and disclosures of healthcare information not covered by this notice or the laws that apply will be made only with your written permission. If you provide permission to use or disclose healthcare information about you, you can revoke their permission in writing at any time. If you revoke your permission I will no longer disclose the healthcare information. I am unable to take back any disclosures already made with your permission. There is a requirement to retain records for the care provided to you.

You have recourse if you believe that your privacy has been violated. You have the right to file a formal written complaint with my office or with the United States Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice or this office's policies and procedures. For more information about HIPPA or to file a complaint with the Federal Government, please call the US Department of Health and Human Services Office of Civil Rights at 877-696-6775 or write them at US Department of Health and Human Services, Attention: Office of Civil Rights, 200 Independence Ave SW, Washington, DC, 20201.

HIPPA Notice of Privacy Practices and Patient Communication Consent

I acknowledge that I have been informed about the Notice of Privacy Practices for Melody Mitchell, LCSW.

I understand that the Notice of Privacy Practices discusses how my personal healthcare information may be used and/or disclosed, my rights with respect to healthcare information, and how and where I may file a privacy related complaint.

I give Melody Mitchell, LCSW permission to share my health information with the following people:

_____

_____

_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Authorization to Disclose Protected Health Information

Patient Name:_____ Phone #:_____
Date of Birth:_____ Address: _____

I authorize Melody Mitchell, LCSW to release protected health information to the following individua(s)/organization:_____
_____
_____

I authorize Melody Mitchell, LCSW to obtain protected health information from the following organization:_____
_____
_____

I understand that I am authorizing my medical/client/educational record for the purpose of continued mental health care. This data shall include the available items checked below:

All Records ☐
Progress/Treatment Notes ☐
Admission Summary ☐
Initial Evaluation ☐
Insurance/Billing ☐
Substance Use ☐
Medication Log ☐
Discharge Summary ☐
Lab Results ☐
Psych/Educational Testing ☐
Other:_____☐

I understand that authorizing the disclosure of information is voluntary. I can refuse to sign this authorization. I have the right to cancel this authorization at any time. I understand that it is my responsibility to notify Melody Mitchell, LCSW if I wish to cancel this authorization. I further understand that Melody Mitchell, LCSW is not responsible for disclosures made based on this authorization prior to the date of cancelation. This authorization will expire one year from the date this form is completed.

Signature:_____Date:_____