IMPORTANT: TO SECURE YOUR INITIAL APPOINTMENT AND ENSURE YOU HAVE MAXIMUM TIME WITH YOUR PROVIDER (AND MINIMIZE TIME FILLING OUT REGISTRATION PAPERWORK), PATIENT MUST COMPLETE, SIGN PCC CONSENT, AND COMPLETE SIGNATURE PAGE PACKET USING ANY OF THE X3 METHODS:

1. **PCC PORTAL: COMPLETE ALL FORMS AND RETURN ELECTRONICALLY VIA SECURE PCC ELECTRONIC PORTAL AT LEAST 72 HOURS PRIOR TO INITIAL OFFICE VISIT. PLEASE PLAN TO ARRIVE AT LEAST 30 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME WITH VALID DRIVERS LICENSE AND CURRENT COPY OF YOUR INSURANCE CARD.**

2. **VISIT WWW.PCCRH.COM TO DOWNLOAD HARDCOPY PDF VERSION OF PCC INTAKE FORMS. PLEASE PRINT, COMPLETE ALL FORMS, AND ARRIVE AT LEAST 30 MINUTES BEFORE SCHEDULED APPOINTMENT TIME WITH COMPLETED FORMS, VALID DRIVERS LICENSE, AND CURRENT COPY OF YOUR INSURANCE CARD.**

3. **PLAN TO COME IN TO THE OFFICE TO COMPLETE ALL FORMS AND PAPERWORK AT LEAST 30 MINUTES OR MORE BEFORE SCHEDULED APPOINTMENT TIME AND BRING VALID DRIVERS LICENSE, AND CURRENT COPY OF YOUR INSURANCE CARD.**

PLEASE NOTE: FAILURE TO DO THE ABOVE MAY RESULT IN YOUR APPOINTMENT BEING CANCELLED OR RESCHEDULED.

Policies and procedures included in this signature packet:

- Psychotherapy Informed Consent for Treatment
- Medication Consent Form (If applicable)
- PCC Telehealth Informed Consent and Addendum
- PCC Informed Consent for In-Person Services During COVID-19 Public Health Crisis
- PCC Consent for E-Mail and Electronic Means of Communication
- Member / Patient's Rights
- Palmetto Counseling Financial Policy
- Receipt and Acknowledgement of HIPAA Notice of Privacy Practices [*Available at]:*
- https://www.pccrh.com/wp-content/uploads/2018/11/Palmetto_Counseling_Privacy_Practices.pdf
- For patients who do not have computer / internet access hardcopy is available upon request

PALMETTO
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PCC Consent for Psychotherapy and Medication Management Services [If applicable]

Today's Date_____

Patient First Name:_____**MI:**_____**Last Name:**_____

Patient Date of Birth:_____**Social Security #:**_____**Gender:**_____

Ethnicity:_____ **Marital Status**_____

Patient Driver's License #:_____**State Issued:**_____

Patient Address:_____**City**_____**State**_____**Zip Code**_____

Home Phone #:_____**Cell Phone #:**_____**Work #:**_____

Email:_____**Ok to leave message? ____Y ____N**

Preferred Contact Method for Appointment Reminders: ____Electronic Text ____Email ____Telephone Msg

Legal Guardian (skip if not applicable):

____Check if Patient is a Minor Legal Custody: ____Mother ____Father ____Joint ____Other

Note: If minor, parent / legal guardian(s) must provide PCC copies of the following legal documents if separated, divorced, or legal guardianship:

- Terms of Legal Separation
- Temporary and/or Final Custody & Divorce Decree
- Legal Guardianship

Important Note: *If parent / guardian of minor patient is unable to provide PCC copies of legal documentation at time of intake, by signing* ***PCC Consent for Psychotherapy and Medication Management Services consent form****, presenting parent / guardian herby acknowledges you have legal authority to make medical & mental health decisions on behalf of child and further confirms you take financial responsibility for child's treatment independent of any other parent or party's consent.*

_____Presenting Parent / Guardian Initials

Emergency Contact List / Family Members involved in Patient's Treatment

Emergency Contact Name:_____**Relationship:**_____

Emergency Contact Address:_____**City**_____**State**_____**Zip**_____

Emergency Contact Phone #:_____**Email**_____

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Insurance Policy Holder / Financially Responsible Person Information

[Please Bring Your Insurance Card and Co-pay Fees to Your Appointment]

PRIMARY INSURANCE

First Name:_____ **MI:**_____ **Last Name**:_____

Date of Birth:_____ **Social Security #**:_____

Address:_____ **City**:_____

State:_____ **Zip code**:_____ **Phone #**:_____

Email:_____ **Policy Holder's Employer**:_____

Insurance Policy Holder Driver's License #:_____ **Primary Insurance Plan Name**:_____

Insurance ID #:_____ **Insurance Group Policy#**:_____

Amount of Co-pay for Specialist $:_____ **Insurance Customer Service#:**_____

SECONDARY INSURANCE (SKIP IF NOT APPLICABLE)

First Name:_____ **MI:**_____ **Last Name:** _____

Date of Birth:_____ **Social Security #:**_____

Address:_____ **City:**_____

State:_____ **Zip code:**_____ **Phone #:**_____

Email:_____ **Policy Holder's Employer:**_____

Insurance Policy Holder Driver's License #:_____ **Secondary Insurance Plan Name:**_____

Insurance ID #:_____ **Insurance Group Policy#:**_____

Amount of Co-pay for Specialist $:_____ **Insurance Customer Service #:**_____

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I understand that I am financially responsible for all deductibles, co-pays and missed appointments, or appointments cancelled without 24-hour notice. I confirm that information I provided is accurate and complete, to the best of my knowledge.
I understand that if I do not inform Palmetto Counseling & Consulting Services, LLC of changes in my insurance coverage before services are rendered, I will be financially responsible for payment in full. I am also responsible for informing Palmetto Counseling & Consulting Services, LLC of any changes in my address, phone number, and emergency contact information.

YOU WILL BE RESPONSIBLE TO FIND A NEW PROVIDER IF YOU FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS WITHOUT PROVIDING 24 HOUR ADVANCED NOTICE.

Assignment of Benefits

I hereby assign, transfer. and set over to Palmetto all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize Palmetto to file (and assign to Palmetto my right to file) my insurance claim under my policy for Palmetto's services. I further authorize the release of any medical information needed to determine benefits, including psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures of psychotherapy and medication management services (if applicable) as defined in the PCC Intake Packet I have received.

_____
Patient Name [Please Print]

_____
Patient Signature Date

_____
Parent / Legal Guardian Signature [If applicable] Date