

PCC Intake Forms Packet (Patient Copy)

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IMPORTANT: TO SECURE YOUR INITIAL APPOINTMENT AND ENSURE YOU HAVE MAXIMUM TIME WITH YOUR PROVIDER, PATIENT MUST COMPLETE, SIGN PCC CONSENT, AND COMPLETE SIGNATURE PAGE PACKET BY EITHER OF THE FOLLOWING METHODS:

1. VISIT WWW.PCCRH.COM TO DOWNLOAD HARDCOPY PDF VERSION OF PCC INTAKE FORMS. PLEASE PRINT, COMPLETE ALL FORMS, SCAN, AND EMAIL COMPLETED PACKET TO INFO@PCCRH.COM (OR SECURE FAX 803-329-5830).
2. PLAN TO COME IN TO THE OFFICE TO COMPLETE ALL FORMS AND PAPERWORK AT LEAST 30 MINUTES OR MORE BEFORE SCHEDULED APPOINTMENT TIME WITH COMPLETED FORMS AND VALID DRIVERS LICENSE.

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

Policies and procedures included in this signature packet:

- PCC Intake Forms - B
- Professional Disclosure Statement (Provisionally Licensed Therapist)
- PCC Informed Consent for Treatment (Provisionally Licensed Therapist)
- Patient / Client's Rights
- Palmetto Counseling Financial Policy
- PCC Consent for E-Mail and Electronic Means of Communication
- PCC Telehealth Informed Consent and Addendum
- PCC Informed Consent for In-Person Services During COVID-19 Public Health Crisis
- 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

Professional Disclosure Statement (Provisionally Licensed Therapist)

We are pleased you have selected Palmetto for your counseling needs. This disclosure will highlight our provisionally licensed staff as they work toward full licensure. Palmetto has recruited highly talented individuals that will become the new generation of fully licensed and independent practitioners. As part of their journey, they are closely supervised as they develop techniques, interventions, and meet with a clinical supervisor to help them grow, develop, and enhance their professional skills.

“Associate licensure” is an authorization to engage in post-degree, supervised professional experience to refine and enhance basic skills, develop more advanced therapeutic skills, and integrate professional knowledge and skills required for private, independent practice. Associate licensure status provides an opportunity, under supervision, for provisional clinicians to do the **same job duties that a fully licensed clinician would be expected to perform (*with exception of being able to participate and bill private commercial and 3rd party payor insurance networks).*

The purpose of this form is to provide information to you regarding your treatment, treatment to you and your family, or the treatment of your minor child. Examples of provisional licenses include LMSW, LPC-A, LMFT-A and LAC-A).

Types of Provisional Licensure

- Licensed Master Social Worker (LMSW)
- Licensed Professional Counselor Associate (LPC-A)
- Licensed Marriage and Family Therapist Associate (LMFT-A)
- Professional Addiction Counselor – Associate (LAC-A)

Requirements

In addition to board-specific requirements, provisionally licensed therapists must have a master's degree or higher from a nationally accredited program, receive 100 supervision hours with an approved clinical supervisor, and successfully pass board exam by their respective governing boards to become fully licensed for independent practice.

Mental Health Services

Palmetto has provided you with information about the Health Insurance Portability and Accountability Act (“HIPAA”). This is a federal law that provides you with certain rights and protections for your Protected Health Information (“PHI”). It is important for you to know how your health information can be disclosed or used for the purpose of treatment, payment, and health care operations. Palmetto has also provided you with a separate NPP, which tells you, more about your privacy rights. That form explains in detail what HIPAA is and how it applies to your health information.

Patient / Client Rights

- You have the right to refuse treatment.
- You have the right to change practitioners or receive referral to another practitioner.
- You have the right and responsibility to choose a practitioner that best suits your needs.
- You have the right to confidentiality. There are exceptions for the reporting of abuse as required by law, danger to self or others, or grave disability/impairment. Please see the “Notice of Privacy Practices” (“NPP”).
- You have the right to raise questions about your treatment or your progress at any time.

Palmetto Counseling Financial Policy

Payment / Fee for Services Model

Please note that provisionally licensed clinicians are unable to bill and participate with private commercial and 3rd party-payor insurance networks. Subsequently, no insurance claim can be filed as all services are considered ‘fee for service’ in which client will be responsible for full payment at the time services are delivered.

The following fees will apply for provisionally licensed clinicians:

- Assessments, Family, Individual, and Couples sessions: \$85 / session
- Group therapy sessions \$40 / session

No Show / Late Cancellation Policy

Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others. If you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place and have no way of recovering lost revenue due to “no-shows” or last-minute cancellations.

Palmetto charges a *\$55 administrative fee for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice (*Note: excludes the cases of severe illness and emergency situations).

I understand that I am responsible for finding a new therapist if I fail to up for two consecutive appointments or multiple no shows without providing 24-hour advanced notices. We will not continue to provide treatment after two no shows. I have read and agree to the above policy terms.

Administrative Fees

The following fees are applicable to all patients_in which patient shall be solely responsible:

Review of Psychological / Medical Forms / Legal Forms / Court Documents / Reports and Letter Completion (Completed Outside of Appointment Times)

- \$50 minimum [pro-rated at \$25 / 15 minutes to complete thereafter]

Non-Crisis Telephone Consult / After-Hours Consult with Clinician

- \$50 minimum [Pro-Rated at \$25/ 15 minutes thereafter]

E-Mail Consult with Clinician

- \$50 minimum [pro-rated at \$25 / 15 minutes to complete thereafter]

Court Appearance / Court Testimony

- \$250 / Hour

***Note: this fee will apply for each hour clinician is required to be present and not specific to time spent providing testimony**

Thank you for understanding the reason behind these fees. We will be reasonable in applying them and notify you when they apply.

Collections: Accounts will be sent to collections after 90 days if not paid as agreed. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys’ fees. In most collection situations, the only information our practice would release regarding a client’s treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim].

An administrative fee of **\$42** will be applied for **all returned checks with insufficient funds.**

Consent for Email and Electronic Means of Communication

As a covered entity under the HIPAA Privacy and Security Rules, we take your privacy and right for confidentiality seriously. Although convenient, email and other forms of electronic communication are not a secure medium because third parties can view and store confidential information. Therefore, email and other forms of electronic communication are not to be considered completely confidential forms of communication, and using email runs the risk of breaching your confidentiality.

Risks of Using Email and Other Forms of Electronic Communication

Transmitting information by e-mail has a number of risks that should be considered before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail senders can easily type in the wrong email address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies or e-mail may exist even after sender or recipient has deleted their copy.
- Employers and on-line services have a right to archive & inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-Mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

Types of Permissible Email or Electronic Communication Client Agrees to Send and/or Receive

- Appointment scheduling requests and appointment reminders
- Billing questions and patient education
- Use of e-mail for general client information only

If you are an active client of Palmetto Counseling and experiencing an urgent, clinical emergency and the office is closed, you may reach the **on-call therapist at (803) 517-3880**. Please leave your name, telephone number and a brief message so that the on-call clinician can assist you. For all other **non-urgent concerns, please contact the office at (803) 329-9639**. Our office hours are 8 am – 5 pm, Monday through Friday or please leave us a voice mail message. If you feel that you have a **life-threatening emergency, call 911 or go to the nearest emergency room**. In addition, contact the **National Suicide Prevention Hotline # 1-800-273-8255 or 1-800-784 2433** to be connected to a skilled, trained counselor at a crisis center 24/7.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that Palmetto’s therapists and practice administrative staff will not accept friend or contact requests from current or former client’s social networking site (e.g., Facebook, LinkedIn, etc.). I understand that adding current or former counselors or practice administrative staff as friends or contacts can compromise my confidentiality and respective privacy.

I have had the opportunity to discuss the above and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the therapist and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the therapist may impose to communicate with patients by e-mail. Any questions I may have had were answered.

PCC TELEHEALTH INFORMED CONSENT

Introduction of TeleHealth:

As a client or patient receiving services at Palmetto Counseling & Consulting Services, LLC through telehealth technologies, I understand:

IMPORTANT: To receive Telehealth services at PCC, client must have a valid, credit card on-file to pay for all applicable copay/session fees [note: credit card information is securely stored with PCC’s credit card processor via PCI-compliant, encrypted vault] or Client must Pre-Pay for all applicable copay/fees prior to Telehealth session.

TeleHealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location. The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

I will need access to, and familiarity with, the appropriate technology to participate in the service provided.

Exchange of Information:

The exchange of information will not be direct, and paperwork exchanged will be via electronic means or through postal delivery. During my telehealth consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio, or other telecommunications technology.

Local Providers:

If a need for direct, in-person services arises, it is my responsibility to contact providers in my area or to contact my behavioral provider's office for an in-person appointment or my primary care physician if my behavioral provider is unavailable. I understand that an opening may not be immediately available in either office.

Self-Termination:

I may decline telehealth services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology:

These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

My provider and I will regularly reassess the appropriateness of continuing to deliver services to me using the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

Disruption of Service:

Should service be disrupted, we will try to utilize alternative for other means of communication.

Provider Communication:

Your provider may utilize alternative means of communication if circumstances should arise
Your provider will typically respond to communications and routine messages within 24 – 48 hours

Client Communication:

It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications. I will take precautions to ensure that my communications are directed only to my provider or other designated individuals.

Client's Electronic Medical Record. Laws & Standards:

The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

ADDENDUM A – ELECTRONIC TRANSMISSION OF INFORMATION:

I, the undersigned, agree to participate in technology-based consultation and other healthcare-related information exchanges with Palmetto Counseling & Consulting Services, LLC, a behavioral health care provider (“provider”). This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named provider, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

It may also mean that my private health information may be transmitted from my provider’s mobile device to my own or from my device to that of my provider via an ‘application’ (abbreviated as “app”). I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment:

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer’s computer or network. I am aware that any information I enter an employer’s computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

TeleHealth Process:

My health care provider has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My behavioral provider has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Additional Services:

I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other health care providers.

Electronic Presence:

In brief, I understand that my provider will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter an “app” will be transmitted electronically to and from myself and my provider.

Limitations:

Regardless of the sophistication of today’s technology, some information my provider would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my provider to understand my problems and to help me get better. My provider will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

I understand that telehealth is a new delivery method for professional services, in an area no yet fully validated by research, and may have potential risks, including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting provider.

Release of Information:

I authorize the release of any information pertaining to me determined by my provider, my other health care providers or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care providers. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:

I also understand that, under the law, and regardless of what form of communication I use in working with my provider, my provider may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives:

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telehealth consultation's effectiveness.

Records:

I understand that my telehealth consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.

I also understand, however, that if my provider, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs.

I hereby authorize these disclosures to take place without prior written consent

Compensation:

I understand that I am not entitled to royalties or to other forms of compensation for participation in any telehealth consultation(s) or other information exchange.

Contact Information:

I have received a copy of my provider's contact information, including their name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable).

I have also been provided with a list of local support services in case of an emergency. I am aware that my provider may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care:

I acknowledge, however, that if I am facing or if I think I may be facing an emergency that could result in harm to me or to another person; I am not to seek a telehealth consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

Release of Liability:

I unconditionally release and discharge Palmetto Counseling & Consulting Services, LLC, its affiliates, agents, employees; and my provider and his or her designees from any liability in connection with my participation in remote telehealth consultation(s).

Final Agreement:

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

With this knowledge, I voluntarily consent to participate in the telehealth consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

PCC INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to conduct in-person services considering the COVID-19 public health crisis. Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all appointments. If there is a resurgence of the pandemic or if other health concerns arise, however, we may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will try to address any issues or concerns. You understand that, if necessary, we may determine that we return to telehealth for everyone's health and well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss (in the event your insurance denies claim(s) for TeleHealth services).

Risks of Opting for In-Person Services

You understand that by electing to come to the office for an in-person visit, you are assuming the risk of exposure to the COVID-19 (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our Team, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

For Your Safety and The Safety of PCC Staff, Please Ensure the Following Protocols Are Followed:

Keep your in-person appointment if you are feeling well and symptom free.

We may take your temperature before coming into the office. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the COVID-19 (including without limitation, a cough, breathing difficulties or sudden loss of taste), you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged our normal cancellation fee.

Wait in your car, outside, or in a designated safe waiting area until 5 minutes before your appointment.

Wash your hands or use alcohol-based hand sanitizer upon entering the building.

Adhere to the safe distancing precautions we have set up in the waiting room and therapy rooms.

You may have to wear a mask in certain areas of the office.

Keep a distance of 6 feet and limit physical contact with others in the office.

You are asked to not bring anyone with you if possible. Should you need to bring your child, you will make sure that your child follows all these sanitation and distancing protocols and is also symptom free.

If you have been exposed to other people who are infected with COVID-19 and have recently been in the office, you will immediately let us know. Depending on the degree of contact, we may deny in-person visits with you for up to 14 days (or such time as is advisable by the Center for Disease Control).

We may change the above precautions if additional local, state, federal orders, or guidelines are published.

Our Commitment to Minimize Exposure

Our practice has taken steps to reduce the risk of spreading COVID-19 within the office and we have posted our efforts on our website and in the office. Please let us know if you have questions about these efforts.

If You or One of Us is Sick

You understand that we are committed to keeping you, our team, and our families safe from the spread of this virus. If you show up for an appointment and we believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. If anyone in our practice tests positive for COVID-19, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for COVID-19, we may be required to notify local health authorities that you have been in the office. If we must report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent and initial intake paperwork that we agreed to at the start of our work together.

OFFICE SAFETY PRECAUTIONS IN EFFECT DURING THE PANDEMIC

Our office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy offices may be re-arranged for appropriate physical distancing.
- Stay and patients are encouraged to wear masks and practice safe distancing.
- Restroom soap dispensers are maintained and encourage everyone to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- You have the option of waiting your car or outside if you are uncomfortable waiting in the waiting area.
- Credit card pads, pens and other areas that are frequently touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.