Farah Halford, LPC, NCC

Psychotherapist

706-987-2429

18 9th St, STE 105

Columbus, GA 31901

Name_____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Ok to leave message at home? _____ Ok to leave message on cell? _____

SSN _____ Date of Birth _____Sex _____ Marital Status _____

Place of Employment _____ Occupation _____

Education_____Religion_____

E-mail address: _____

Spouse _____

Date of Birth _____ SSN _____Sex_____ Cell Phone _____

Place of Employment _____ Occupation _____

Education _____ Religion _____

Children (list names and ages)

_____ _____

_____ _____

Name of your Primary Care Physician

_____

How were you referred to us?

_____

May we send a letter of acknowledgement to the person who referred you to our office?

Yes_____ No_____

Emergency contact: Name _____Phone number_____

Relationship_____

Please tell us days/times that you are available for appointments:

_____

_____

Please note: Cancellations require a 48-hour prior notice. Please see Policies and Procedures.

Briefly describe your reasons for seeking treatment, list your current symptoms and difficulties:

_____

_____

_____

_____

List significant previous or present physical problems/diagnoses and dates:

_____

_____

_____

_____

List current medications, including dosage, starting date and prescribing physician:

_____

_____

_____

_____

Any allergies?

_____

Are there any other special circumstances or problems you are concerned about (i.e., legal, work, family, financial)? List sources of stress:

_____

_____

_____

_____

Previous psychological and/or psychiatric treatment/hospitalization; List dates, therapists, reason for therapy and outcomes:

_____

_____

_____

Describe any drug/alcohol abuse; include 1) current use, 2) amount and 3) history of abuse/dependency treatment:

_____

_____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND ALL POLICIES AND PROCEDURES AND AGREE TO ABIDE BY ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE AND HEREBY GIVE CONSENT TO BE TREATED.

Signature_____ Date_____

Guarantor Financial Responsibility

Every patient is responsible for knowing the specific requirements of their insurance companies. With so many different insurance plans, it is unrealistic for us to know the specific requirements for all policies. Please let us know if you are required to have or use one of the following:

1. Authorization/Pre-certification requirement for mental health treatment.

2. A written referral from your Primary Care Physician (PCP).

It is the patient's responsibility to obtain referral prior to their appointment. If you are unsure about your insurance requirements, please contact your employer's personnel/human resources representative at your work or your insurance agent prior to your appointment.

I have read the above and understand that it is my responsibility to make sure all insurance requirements are fulfilled. It is also my responsibility to notify this office of any changes in my insurance. I agree to be responsible for all charges incurred with Farah Halford, LPC or Elevated Wellness that result from non-covered services or patient's failure to meet insurance requirements.

Signature_____ Date_____

Late Cancellation/Missed Appointment Policy

Our current late cancellation/missed appointment policy is unique to psychotherapy practices. We ask that you read it and consider it carefully to reduce the chance of misunderstandings that may hinder your progress in therapy. We reserve a therapeutic hour for each person(s) scheduling an appointment; and our income is based entirely on the hours we see patients. If someone cancels late or misses an appointment, we incur a loss of income for that hour and are not able to offer that time to someone who may be waiting, possibly in crisis. Therefore, we must have an agreement that the appointment will be kept or, if you must cancel, we need to have ample notice in order to avoid this type of loss. Regardless of cause we require a 48-hour notice on a cancellation in order to release you from your responsibility for that time scheduled. You will be billed $75.00 for late cancellations and missed appointments. Please note that insurance companies do not reimburse for cancelled sessions. If you have circumstances that may make it difficult for you to keep your appointments, please discuss this with your therapist during your intake session.

I/we agree to the above terms of the late cancellation/missed appointment policy. I fully understand the therapeutic and economic necessity of such a policy.

Signature_____ Date_____

Signature_____ Date_____

E-mail Policy

1. RISK OF USING E-MAIL

Transmitting client information by e-mail has a number of risks that clients should consider before using e-mail. 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 received by many intended and unintended recipients.

• E-mail senders can easily misaddress an e-mail

• E-mail is easier to falsify that handwritten or signed documents.

• Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.

• Employers and on-line services have a right to archive and 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.

2. CONDITIONS FOR THE USE OF E-MAIL

I/we will use reasonable means to protect the security and confidentiality of e-mail information to be sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the clients must consent to the use of e-mail for client information. Consent to the use of e-mail includes agreement with the following conditions:

• Provider will not forward e-mails to independent third parties without client's prior written consent, except as authorized or required by law.

• Although Provider will endeavor to read and respond promptly to an e-mail from a client, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the client shall not use e-mail for emergencies, crises or other time sensitive matters.

• If the client's e-mail required or invites a response from Provider, and the client has not received a response within a reasonable time period, it is the client's responsibility to follow up to determine whether the intended recipient will respond.

• The client should not use e-mail for communication regarding sensitive information.

• The client is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the client or any third party.

• Provider shall not engage in e-mail communication that is unlawful.

• It is the client's responsibility to follow up and / or scheduled an appointment if warranted.

3. INSTRUCTIONS To communicate by e-mail, the client shall:

• Inform Provider of change in his / her e-mail if necessary.

• Put the client's name in the body of the e-mail.

• Include the category of the communication on the e-mail's subject line, for routing purposes (e.g. resource, appointment change, and etc.).

• Review the e-mail to make sure it is clear and that all relevant information is provided before sending to Provider.

• Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his / her computer password.

• Withdraw consent only by e-mail or written communication to Provider.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

Signature on this document ONLY acknowledges receipt of this policy and additional information. Signature DOES NOT constitute consent for e-mail communication. Client initiation of contact with Provider via e-mail will constitute consent for email communication, within the above guidelines, unless otherwise communicated in writing.

Signature_____ Date_____

Please select your preference in how you will receive your services with me:

Telehealth (virtual) only _____ In-Person only_____ No Preference _____

Please note that all new patients are required to complete Telehealth Information and Informed Consent. Refusing telehealth services may limit access to some providers.

TELEMENTAL HEALTH CLIENT CONTACT INFORMATION

Client Name _____ DOB_____ Phone _____

Address_____

Email Address_____

Emergency Contact Name _____Relationship to Client_____

Emergency Contact Phone _____

Release of Information: *Your signature below allows for a limited release of information to the above listed emergency contact/and or emergency response personnel. This release will allow your provider to notify your emergency contact if there is a medical emergency which occurs during the course of a Telemental health appointment. The purpose of this release is to only allow information needed for your provider to facilitate addressing any medical crisis during the course of the session only. This does not apply to any setting except an active Telemental health appointment or allow for any information to be released outside of a non-emergency setting.*

Signature: _____ Date: _____

INFORMED CONSENT FOR TELEMENTAL HEALTH

This Informed Consent for Telemental Health contains important information focusing on doing psychotherapy using the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Risk and Benefits of Telemental Health

Telemental Health refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing. One of the benefits of Telemental Health is that the client and clinician can engage in services without being in the same physical location. Telemental Health, however, requires technical competence on both our parts. There are benefits, risk, and differences of Telemental Health when compared to in person psychotherapy. For example:

- **Risks to confidentiality.** There is potential for other people to overhear sessions if you are not in a private place during the session. I will take reasonable steps to ensure your privacy from my location. But it is important for you to make sure you find a private place for our session where you will not be interrupted. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- **Issues related to technology.** Technology may stop working during session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized persons or entities.

- **Crisis management and intervention.** Telemental Health is not a viable option of high-risk clients. Before engaging in Telemental Health, an emergency response plan will be developed to address potential crisis situations that may arise during our Telemental Health work.

- **Efficacy.** Some research shows that Telemental Health is almost as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

Doxyme, a secure, HIPPA approved, telemedical platform is used in my office. For communication between sessions, I use email communication, phone, and text messaging with your permission and only for administrative purposes unless we have made another agreement. I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text. I do not regularly check my email or texts, nor do I respond immediately when I am with other clients or after hours, so these methods should not be used if there is an emergency. I the case of an emergency please contact your family physician or the nearest emergency room.

Confidentiality

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in Telemental Health. Please let me know if you have any questions about exceptions to confidentiality.

Emergencies and Technology

If the session is interrupted for any reason, such as power loss, interruption of internet, or technological issues disconnect from the session and I will wait one (1) minutes and then re-connect via the Doxyme platform. If you do not receive a call from me within two (2) minutes, then call me on the following phone number: 706-987-2429. If we are unable to reconnect, you will be charged a pro-rated fee only.

Fees

Please contact your insurance company prior to any Telemental Health sessions to determine whether Telemental Health sessions are covered by your provider. If your insurance does not cover Telemental Health sessions, you will be solely responsible for the entire fee of the session. The fee rates are the same as in person therapy.

Records

The Telemental Health sessions are not to be recorded. I will maintain a written record of our session in your file.

Informed Consent

This agreement is intended not as a replacement for the informed consent but as a supplement for those receiving Telemental Health. Your signature below indicates agreement with its terms and conditions.

Signature: _____ Date: _____

Policies and Procedures

Please read this information, and feel free to discuss any questions you may have. Please keep a copy for your records.

Health Insurance Portability and Accountability Act (HIPAA)

This document contains important information about professional services and policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Georgia Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. When you sign this document, it will also represent an agreement between us.

Confidentiality

All communications between client and therapist will be held in confidence, and will not be revealed to anyone unless you (or parent, in the case of a minor) give written authorization to release this information. Your legal right to privileged communication between a licensed psychologist and a client will be upheld unless overruled in a court of law during a legal proceeding. Georgia law requires that confidentiality be waived when the patient's or other's personal safety is threatened or when disclosure of child abuse or elderly abuse is made to the therapist. If we determine that a patient poses a serious danger to themselves or to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. Occasionally, your therapist may choose to consult colleagues about your case. Your identity will be protected during these consultations. We request that you complete a Release of Information form so that we may be in contact with your primary care physician. Information routinely released to insurance companies for reimbursement for services shows only a diagnosis, the dates of service, charges and payments. In order to file your insurance, it is necessary for you to sign the Release of Information form.

You may recognize other people here. We expect you to maintain confidentiality concerning the identities of these people. If it is necessary to contact you at home or work, we will be discrete. If we happen to see each other in a public setting, I will not speak to you, unless you speak to me first.

Contacting Us

Due to schedules, we are often not immediately available by telephone. Even if I am in the office, I will not answer the phone when with other patients. When I am unavailable, you may leave a voicemail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your primary care physician or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the names of colleagues to contact, if necessary.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of records. One set constitutes your PHI. It includes information about your reasons for seeking therapy, a summary description of the ways in which your problem impacts on your life, your diagnosis, the goals we set for treatment, your progress towards goals, your pertinent medical history, your treatment

history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. In addition to the PHI, I also may keep a set of Psychotherapy notes. These notes are for my own use and assist me in providing you with the best treatment. Psychotherapy notes are kept separate from your PHI. Your Psychotherapy notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization.

Medical Support Services

Sometimes the most effective and efficient treatment of psychological problems requires the use of medication and/or hospitalization. Your primary care physician or a psychiatrist may be consulted to assist in these matters.

Minors and Parents

Patients under 18 years of age and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or be counter therapeutic. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Termination of Treatment

Termination of treatment should always be discussed with your therapist. Termination will occur automatically if you have not been seen in a therapy session for 6 weeks from the date of your last attended session, unless there is a prior agreement.

Financial Arrangements and Insurance

During your initial visit to our office, we will discuss the hourly charge for our services the terms of payment, filing for health insurance, reimbursement and any other questions you may have regarding financial procedures. The following procedures are provided for your information:

1. For out of pocket individual therapy the session cost is $100.00 for a 53-minute session. Family and couples' sessions cost is $125.00 for a 53-minute session. Records can be sent to you if you plan to file your sessions with your insurance company. It is your responsibility to pay your bill.

2. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You, not your insurance company, are responsible for full payment. I use Headway to manage health insurance payments and claims. If you are using Atena, Cigna, or Anthem BlueCross, you will need to create an account with Headway. If your insurance company is unwilling to pay, it is your responsibility to make payment and contact the insurance company.

3. It is very important that you find out exactly what mental health services your insurance policy covers and if you need to obtain a preauthorization. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a

person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. I am required to provide a clinical diagnosis to your insurance company. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Personal Health Information. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. By signing this Agreement, you agree that I can provide requested information to your carrier.

4. Because your time is reserved just for you, you will be billed for any appointment cancelled without prior notification. Please see attached Late Cancellation/Missed Appointment (No Show) Policy.

5. In addition to therapy appointments, I charge $175.00 per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, any telephone conversations that are clinical in nature, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the complexity of legal involvement, we charge $300 per hour for preparation and attendance at any legal proceeding as well as consultation time with attorneys.

7. You are encouraged to ask questions regarding any aspect of your treatment.

8. In respect to minor children, the custodial parent or legal guardian needs to provide signatures on all documents.

GEORGIA NOTICE FORM

Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION 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

I 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 record that could identify you.

• "Treatment" Payment and Health Care Operations"

-Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example would be when I consult with another health care provider, such as your primary care physician or another therapist.

-Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose 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 my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits, case management, and care coordination.

• "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or 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 we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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

III. Uses and Disclosures with Neither Consent nor Authorization

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

• Serious Threat to Health or Safety- If I determine that you present a serious danger to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

• Child Abuse- If I have reason to believe that a child has been abused, we must report the alleged abuse to the proper authorities.

• Elder and Disabled Abuse- If I have reason to believe that a disabled adult or elder person has been abused, neglected, or exploited, we must report the alleged offences to the appropriate authorities.

• Mental Health Oversight Actions- If I am the subject of an inquiry by the Georgia Board of Licensed Professional Counselors, I may be required to disclose protected health information regarding you in proceedings before the Board.

• Judicial and Administrative Proceedings- If you are involved in a court proceeding and a request is made about the professional services I provided for you or the records thereof, such information is privileged under state law, and we will not release information without your written consent 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.

No Surprises Act Notice

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you unless you give written consent and give up your protections.

You’re never required to give up your protection from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn't allowed, you also have the following protections:

• You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
• Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact: Georgia Secretary of State (404) 656-2817

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under Federal law.

Visit https://oci.georgia.gov/news/2020-12-30/office-commissioner-insurance-and-safety-fire-posts-final-surprise-billing for more information about your rights under Georgia state laws.