Danny E Daniel, LPC-S, LMFT & BC-TMH

Psychotherapist

Behavioral Health Specialists, LLC

The Quarter 1855 Lakeland Dr. Bldg P-121

Jackson, MS 39216 (601) 366-4696

www.behavioralhealthspecialists.net

INTAKE INFORMATION

PATIENT'S NAME_____
FIRST INITIAL LAST

PARENTS OF MINOR_____

ADDRESS_____CITY_____STATE_____

Cell #_____PATIENT'S BIRTHDATE_____AGE_____

EMAIL ADDRESS_____

INSURANCE INFORMATION

PRIMARY INSURED'S NAME _____

INSURED'S ADDRESS_____

INSURED'S BIRTHDATE_____ INSURANCE COMPANY_____

POLICY NO. _____REFERRAL SOURCE_____

CHIEF CONCERN

Please describe the main difficulty that has brought you to the clinic:

_____
_____
_____
_____
_____
_____
_____

Please read and sign the following pages

INFORMED CONSENT

Thank you for choosing ***Danny E Daniel, LPC-S, LMFT & BC-TMH****. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.* ***Danny E Daniel, LPC-S, LMFT & BC-TMH*** *has earned a Bachelor of Arts Degree in Religion with a minor in psychology from Athens State College, and a Masters Of Arts Degree in Religion from Wesley Biblical Seminary. Also, a Masters of Counseling Psychology Degree was earned from Mississippi College. He is licensed by the State of Mississippi as a Licensed Professional Counselor, Licensed Marriage and Family Therapist and Board Certified Telemental Health professional. He has over twenty years of clinical experience in treating adolescents, adults and families using individual, family and group therapy.* ***Danny E Daniel, LPC, LMFT & BC-TMH*** *practices standard cognitive behavioral type therapies for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.*

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information you and/or your child or children report about physical or sexual abuse; then, by Mississippi State Law, I am obligated to report this to the Mississippi Department of Human Services, b) if you provide information that informs me that you are in danger of harming yourself or others, c) where you sign a release of information to have specific information shared, d) information necessary for case supervision or consultation and e) when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact emergency services in the community (911) for those services and/or a local hospital emergency room.* ***Danny E Daniel, LPC, LMFT & BC-TMH*** *will follow those emergency services with standard counseling and support to the client or the client's family.*

Signature(s)_____Date:_____

Financial/insurance issues: Currently we will only be accepting Blue Cross Blue Shield (BCBS) and State (AHS) insurance plans. If you have coverage with another insurance company, as a courtesy we will provide a receipt with which you can file with your own insurance. We ask that at each session you pay your co-pay or 50% of the fee. These fees can be paid by either check or credit card***. In the event you have not met your deductible, the full fee is due at each session.*** If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00, we will need to ask that you pay for services when rendered. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). Lastly, we ask that every client authorize payment of medical benefits directly to Danny E Daniel, LPC-S, LMFT & BC-TMH. We sincerely appreciate your cooperation. If you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

Signature(s)_____Date_____

The following are the Fees for Services Rendered (revised 3/1/2014):

SERVICES	CPT Codes	AMOUNT
Initial Evaluation (50-60 Minutes)	90791	$ 200.00
Individual Psychotherapy (20 Minutes)	90832	$ 90.00
Individual Psychotherapy (40 Minutes)	90834	$ 130.00
Individual Psychotherapy (53-60 Minutes)	90837	$ 190.00
Family Psychotherapy (50 Minutes) w/patient w/o patient	90847 90846	$ 175.00 $155.00
Group Therapy (80 Minutes)	90853	$ 65.00
Miscellaneous		

I have read and understand the current fee schedule. Please initial:_____

Lastly, if you need to cancel or reschedule an appointment, please give ***48 business hours advance notice,*** *otherwise* ***your credit card on file will be charged at the reduced hourly rate of $145.00.*** *We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.*

Signature(s)_____Date_____

COORDINATION OF TREAMENT:

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no information will be shared.*

_____You may inform my physician(s) _____I decline to inform my Physician

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

Signature(s)_____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____ maybe treated as a client by ***Danny E Daniel, LPC, LMFT & BC-TMH****. All appointments that are after hours i.e. 5:00 p.m. or later, it may be necessary for the guardian to remain present in waiting area while session is being conducted. We ask for your cooperation in order that, we provide the timeliest treatment for you and your child.*

Signature(s)_____Date_____

FEE SCHEDULE

SERVICES	CPT Codes	AMOUNT
Initial Evaluation (50-60 Minutes)	90791	$ 200.00
Individual Psychotherapy (30 Minutes)	90832	$ 90.00
Individual Psychotherapy (45 Minutes)	90834	$ 130.00
Individual Psychotherapy (60 Minutes)	90837	$ 190.00
Family Psychotherapy (50 Minutes) w/patient w/o patient	90847 90846	$ 175.00 $155.00
Group Therapy (60-80 Minutes)	90853	$ 65.00
Miscellaneous		
Minimal phone consultation or correspondence (under 15 minutes)	NA	No Charge
Extensive phone consultation or correspondence (more than 15 minutes)	NA	$ 45.00 per quarter hour rounded up to nearest quarter.
Missed appointment (hourly rate)	NA	$ 145.00

Financial/insurance issues: Currently we will only be accepting Blue Cross Blue Shield (BCBS) and State (AHS) insurance plans. If you have coverage with another insurance company, as a courtesy we will provide a receipt with which you can file with your own insurance. We ask that at each session you pay your co-pay or 50% of the fee. These fees can be paid by either check or credit card. ***In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied.*** If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds, $300.00, we will need to ask that you pay for services when rendered. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to Danny E Daniel, LPC-S, LMFT & BC-TMH. We sincerely appreciate your cooperation. If you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

AGREEMENT ON SUBPOENA AND INDEMNIFICATION

By signing this agreement, I as a client or as the parent/guardian of a client agree to the following terms:

1. I will not attempt to compel Danny Daniel's appearance in court, individually or as a representative of Behavioral Health Specialists, LLC, in a deposition or in any aspect of a litigated matter.

2. If I do attempt to compel Danny Daniel's appearance in any matter contrary to provision #1, I agree to compensate Danny Daniel for his time at the rate of Two Hundred Fifty Dollars ($250.00) per hour including preparation time, travel time, waiting time, deposition time and presentation time with a minimum of four hours **and** to indemnify Danny Daniel for any attorney's fees he may incur as the result of my actions.

3. If a non-party to this agreement attempts to compel Danny Daniel's appearance, individually or as a representative of Behavioral Health Specialists, LLC, as a direct result of this counseling relationship, I agree to indemnify Danny Daniel and to reimburse him for any attorney's fees he may incur in defending against such an effort to compel his participation in a litigated matter.

4. Finally, I agree to indemnify Danny Daniel for any attorney's fees he may incur as a result of his efforts to enforce this agreement.

Witness my signature, this _____day of _____, 20____.

_____Patient, parent or guardian.

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: January 1, 2007

Danny E Daniel, LPC-S, LMFT & BC-TMH has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT.

We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources?

PAYMENT. Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS. We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Mississippi State Law, we are obligated to report this to the Department of Human Services. If you provide information that informs us, that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Patient Compliance Contract

We are thankful you have chosen us for your healthcare needs. In order for us to serve you best, it is important that you understand your role in your treatment.

Patient's Name: _____

1. **Appointment compliance**. The physicians and therapists at this clinic have developed a treatment plan for you and improvement depends on your attendance on a regular basis. It is important that you schedule your appointments as directed by your treatment team. Please keep all scheduled appointments. The clinic has a cancellation policy which requires at least 48 hours prior notice of any cancellations or changes in your appointment time. Changes or cancellations of appointments made less than 48 hours ahead of your appointment time **WILL BE CHARGED** to your credit card on file.

2. **Treatment compliance**. It is important to continue therapy and any medications your physician has prescribed for you exactly as he has prescribed. Please do not skip doses or alter your dosage without physician instruction. This can be dangerous with any medication.

3. **Patient contact information**. Please make the clinic aware of any changes in your contact information, such as phone numbers and address. The clinic staff will make a good faith effort to call and remind you of your scheduled appointment a couple of days ahead of time, but **it is your responsibility to keep all appointments that you have scheduled.**

4. In the event that you **have three or more NO SHOWS for scheduled appointments**, the clinic reserves the right to discharge you from the clinic. In this case, we will forward your medical records to a physician or therapist of your choice.

5. The patient will incur a prescription refill fee for any lost prescriptions, or unscheduled refills, and also for some refills between appointments. The clinic may charge a fee for phone calls regarding medical questions.

6. **The clinic policy states that every patient must have a credit card number on file before any appointments are scheduled.** Please provide this information below:

CC # _____ Exp. Date_____ CVV_____

Name on card_____ Zip Code:_____

Parent/Guardian signature: _____ Date:_____

Basics of Telemental Health:

The client should:

- Avoid using mind altering substances prior to session
- Dress appropriately during web-based sessions as you would if you were attending a session at your counselor's office
- Hold the session in a room that is appropriate for a web-based session, such as a home office
- Do not have anyone else in the room unless you first discuss it with your counselor
- Not conduct other activities while in session, such as driving
- Not bring any weapons of any kind to session (based upon clinical judgment)
- Do not record sessions without first obtaining the provider's approval.
- Be located within the states in which the clinician is licensed to practice (client should inform the clinician of their location)
- Minors should have a parent or guardian with them at the location/building of the web-based session, unless otherwise agreed upon with their counselor.

Back up plan for technology failure:

- The most reliable backup is a phone. Therefore, it is recommended that you always have a phone available and that I, your therapist, know your phone number.
- If you get disconnected from a video conferencing, chat, or texting session, end and restart the session. If you are unable to reconnect within five minutes call me. If I do not hear from you within ten minutes you agree (unless you request otherwise) that I can call you on the phone number you provide on the client information form.
- If you are on a phone session and your phone disconnects call me back or contact me to schedule another session. If I do not hear from you within ten minutes you agree (unless you request otherwise) that I can call you on the phone number you provide on the client information form. If this happens as a result of my phone or phone service, and we are not able to reconnect, you will not be charged for the session.

Recommendations for the Client:

- Conduct the sessions in a private location where others cannot hear you.
- If someone enters your location during the session acknowledge them so that your counselor will know that there is someone else in the room.
- Only use devices and internet services that you trust are secure.
- Password protect your computer, tablet, phone, and any other device with a password that is unique.
- Always log out of your sessions.
- Do not have any software remember your password. Sign in every time.

- Do not share your passwords with anyone.
- Do not share your computer when you are logging on to any counseling software.
- If you wish to avoid others knowing that you are receiving counseling services, clear your browser's cache (browsing history), and on your phone, list your therapist by a name rather than as "counselor or therapist."
- Have all of your devices set to time out requiring you to sign back in after a set idle time.
- Keep your computer updated.
- Use a firewall and antivirus program.
- Do not record any sessions.
- Using secure video conferencing technology.
- Notify your counselor if you suspect any breach in your security.
- When online do not login as an administrator.
- Using your own Router / Access Point
    - Only use a secure network for internet access using a WAP2 security key.
    - Use your own administer ID and password (not the default) for your router or access point.
    - Choose a custom SSID name, not the default name.
    - Limit the range of you Wi-Fi by positioning it near the center of your home.

Informed consent for Telemental Health

In addition to the existing informed consent for treatment that has already been completed for in office visits, state law requires counselors wishing to engage in telemental health (TMH) to provide additional information concerning distance counseling. Further, I wish to clarify business policies that may differ from policies that take place face-to-face in an office setting. By agreeing to the following items, you acknowledge and agree to adhere to these policies.

- **First**, the location of telemental health services on the part of the provider will always be provided in a secure, private location so as to ensure that confidentiality and privacy are maintained. Prior to beginning each teleconferencing session, the counselor will enquire to make sure that the patient's location is also secure and private. It should be noted here, though, that due to limitations on the counselor, that privacy and confidentiality cannot be guaranteed for the patient's immediate environment. It is recommended that if any questions of confidentiality or privacy exist, that the patient should change venues or request to reschedule with provider. No penalties or cancellation fees will be incurred due to an insecure location on the patient's part.
- **Second**, all sessions done via distance counseling or teleconferencing will be done over a HIPAA-compliant, secure connection.
- **Third**, a thorough safety plan will be enacted in order to protect clients experiencing severe distress or other emotions. This plan will include:
    - In the event of connection failure, therapist will attempt to reestablish connection via video so that therapy can continue. If after 10 minutes connection cannot be restored, counselor will contact client via telephone to conclude session and check-out with client to ensure client is stable and reschedule next appointment.
    - During the first session, client and counselor will verify emergency contact person and verify emergency services contact numbers in the client's physical area, not in the area dictated by phone/internet service. If an emergency occurs, 911 is routed to the caller's service area, which is not necessarily where the client is located.
- **Finally**, because of the nature of a distance relationship, copays/fees will be processed via credit card at the beginning of the session. All fees will remain the same as in the fee schedule signed in the original intake paperwork.

If any questions or comments exist, please don't hesitate to contact me so that worries can be addressed and laid to rest.

_____ _____

Patient's signature Date

_____ _____

Parent/Guardian/Responsible party signature Provider's signature