Authorization For Treatment And Billing Services

CLIENT NAME: _____

Date of Birth: _____

If minor child, name of Parent/Guardian: _____

I understand the following:

- I am requesting outpatient mental health services at Lakeview Counseling.
- These services are confidential and information cannot be released without my written consent.
- If I feel my civil, treatment, or personal rights have been violated, I can report it to the State of Michigan, and/or the Department of Mental Health, and/or the Department of Commerce.
- I am fully responsible for paying any fees not covered by my insurance company or other third party payment source.
- Payment is required at the time of service unless other arrangements have been made.
- A monthly late fee may be charged if monthly payments are not received.
- I must inform Lakeview Counseling of any changes in my insurance benefits.
- I must give a minimum of 24 hours notice if I cancel an appointment. Failure to do so will result in a charge up to a full session.
- Accounts which are delinquent will be subject to a collection process.
- I must inform Lakeview Counseling of any changes to my contact information (i.e. address, name, phone numbers, etc.)

I authorize the release of any information necessary to process insurance/billing claims as well as payment of all Mental Health insurance benefits to be made directly to Lakeview Counseling. I have received the Notice of Privacy Practices and have been provided with an opportunity to review it. I have been provided with the HIPAA information.

Client or Parent/Guardian Signature _____ Date _____

Spouse Signature (if conjoint therapy is taking place) _____ Date _____

For Treatment Of Person(s) Under The Age Of 18

Based on the laws of the State of Michigan and the guidelines of the therapist's profession, the rules concerning privacy will be used. I can maintain contact with the therapist via telephone or per a scheduled appointment time. I can request a written report or summary of services provided to the minor. I agree that I am the parent accepting responsibility for provision of insurance or other third party information and the payment of fees. I understand that Lakeview Counseling cannot charge or bill any other parent, guardian or third party entity without their permission.

My signature below means that I understand and agree with the points stated above.

I, _____, the parent/legal guardian of the minor, _____ give my permission for this minor to receive therapy services at Lakeview Counseling, PC.

Client or Parent/Guardian Signature _____ Date _____

333 West Grandview Parkway, Suite 403, Traverse City, MI 49684
(231) 929-0300 | Fax (231) 933-6378

Billing Information

CLIENT NAME: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Telephone: _____

PRIMARY INSURANCE: _____

Contract #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Subscriber's Relationship to Client: _____ Subscriber's Employer: _____

Subscriber's Address if different than client's: _____

OFFICE USE:

Date Called: _____ Spoke with _____

Policy Year: Calendar/Renewal Month _____ COB? YES [ ] or NO [ ]

Deductible: _____ Deductible amount met: _____

Co-pay/ins: _____ Unlimited Visits: YES [ ] or NO [ ]

Authorization Required: YES [ ] or NO [ ]

SECONDARY INSURANCE: _____

Contract #:_____ Group #: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Subscriber's Relationship to Client:_____ Subscriber's Employer: _____

Subscriber's Address if different than client's: _____

OFFICE USE:

Date Called: _____ Spoke with _____

Policy Year: Calendar/Renewal Month _____ COB? YES [ ] or NO [ ]

Deductible:_____ Deductible amount met: _____

Co-pay/ins:_____ Unlimited Visits: YES [ ] or NO [ ]

Authorization Required: YES [ ] or NO [ ]

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Credit/Debit/HSA/HRA Card Agreement

Lakeview Counseling, PC has implemented a policy which requires clients to pay for visits and copays at the time of service by cash, check or by choosing to use and maintain a valid Credit/Debit/HSA/HRA card on file with us. All applicable No-Show or late cancellation (less than 24 hours) fees will be charged to this card unless specified otherwise.

By providing us with your card information, you are consenting to Lakeview Counseling, PC to automatically charge the card on file for you, or any other client(s) listed below at the time of service or following a missed/late cancellation appointment.

Card Information

Credit ☐ / Debit ☐ / HSA ☐ / HRA ☐
***Please indicate type of card**

Card Holder's Name: _____

Card Number: _____ Exp. Date: _____

CVV code: _____ (3-digit code on back)

I authorize the above card to be used for the following individuals:

Name: _____

Name: _____

Name: _____

Name: _____

☐ **I agree to the use of the card on file to be charged for all fee's acquired with my services at Lakeview Counseling, PC**.

Card Holder's Signature: _____ Date: _____

You Can Pay Your Balance Using Visa, Mastercard or Discover

Three Simple Steps:

(1) Visit lakeviewtc.com/online-payment/

(2) Click the "Pay Here" button to use our secure online portal.

(3) Complete and submit your payment information.

Charges will appear on your credit card statement from "Merchant Bank".

If you have any questions, please contact us.

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Telehealth Informed Consent

I, _____, hereby consent to participate in telehealth communications with _____, as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media orother electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telehealth:

1. I understand that I have the right to withdraw consent at any time without affecting my right tofuture care or services.
2. I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where thedisclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information(PHI) also apply to telehealth services unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotionalhealth as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care may be required.
6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call (231) 929-0300 to discuss, since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/orappropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact onyour behalf in a life- threatening emergency only. This person will only be contacted to go to yourlocation or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone is: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

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