Methodist
SERVICES

Welcome.

We look forward to accompanying you on your journey to wellness!

Interested in counseling services at our Bangor or Easton locations? Please contact the Intake Coordinator at 610-588-9109 x318. The Intake Coordinator will conduct a brief pre-screening interview to help ensure that Community Counseling Services will be able to fully meet your therapeutic needs.

The intake packet includes forms that can be completed and submitted at the time of your initial intake session. Please feel free to contact us with any questions that you may have.

Methodist SERVICES

INFORMED CONSENT FOR TREATMENT

I _____(name of client) agree and consent to participate in behavioral healthcare services offered and provided by Methodist Services - Community Counseling Services (CCS). I understand that I am consenting and agreeing only to those services that my assigned therapist and/or psychiatrist (a medical doctor who can prescribe medication to assist in the treatment of mental health disorders) is qualified to perform within the scope of his/her education and training, license and/or certification. *Referrals to other providers will be given for issues/diagnoses beyond the scope of competent practice of CCS' staff.* I understand that all information I provide to CCS staff is kept in the strictest confidence, and no information will be released without my written consent or as permitted by law. Behavioral healthcare services at CCS are based on the attainment of treatment goals. I understand that I am expected to participate fully in my treatment which includes identifying and working towards the achievement of these goals. Additionally, I understand that mental health professionals not involved in my direct treatment may be consulted as members of CCS' Treatment Team led by the agency Medical Director.

I agree to the copay (if applicable) designated by my insurance company to be paid prior to the start of each therapy and/or medication management appointment. I understand that it is my responsibility to stay informed of my insurance plan's policy and benefits changes and communicate these changes with CCS when applicable. Should my insurance company refuse payment for any reason or my insurance is cancelled, I agree to make full payment at the rates agreed upon less any fees previously paid. I understand that as a courtesy to me Methodist Services-Community Counseling will assist me in acquiring payment from my insurance company (when applicable). *I understand that my assigned therapist and/or psychiatrist at CCS does not know if I have a deductible, what my co-pay amount is, or what my insurance plan allows for and it is my responsibility to know this information.* I also understand that all unpaid fees may be forwarded to a collection agency after 60 days of nonpayment.

I understand that it is critical to my treatment success that I attend all scheduled appointments. If I need to cancel an appointment, I must provide CCS with 24 hour notice via a voice message. I understand that CCS may charge clients a $20.00 fee for missed appointments (with the exception of those clients whose insurance does not permit this practice). *Automated appointment reminders will be made to the telephone number I have provided unless I refuse this service in writing.* Consistent no shows, cancellations, non-compliance, or 60 days of case inactivity will result in discharge from services. I understand that if I wish to return to services at CCS following discharge, I will need to call the Intake Coordinator. I agree to comply with agency policies and procedures when receiving services at CCS.

My signature below indicates that I understand and agree with these terms (If the client is under the age of 14 or unable to consent to treatment, I attest that I have legal custody of this individual and I am authorized to initiate and consent for treatment and /or I am legally authorized to initiate and consent to treatment on behalf of this individual. I understand that I may be asked to provide the relevant legal documentation giving me this authority.)

_____ _____

CLIENT DATE

_____ _____

PARENT/GUARDIAN/AUTH REP DATE

I HAVE RECEIVED & REVIEWED THE PROGRAM BROCHURE THAT INCLUDES HOURS OF OPERATION AND EMERGENCY PROCEDURES AND I UNDERSTAND ITS CONTENTS.

INITIAL: _____ DATE: _____

Methodist Services Community Counseling
General Information

NAME:_____ **DATE OF BIRTH:**_____
RACE: ___White ____Black/African American ____ American Indian/Alaska Native ____Asian ____Hawaiian/Pacific Islander ____ Decline to Specify
ETHNICITY: _____Hispanic or Latino _____Not Hispanic or Latino _____Decline to Specify
GENDER:_____
PARENT/GUARDIAN (If under age18):_____
ADDRESS:_____
PRIMARY NUMBER:_____**SECONDARY NUMBER:**_____

It is the policy of Methodist Services-CCS to protect your confidentiality. No medical information or personal history will be released to anyone without a formal Release of Information which can be obtained at the Reception Desk. However, please provide the office staff with an emergency contact below.

EMERGENCY CONTACT:_____ RELATIONSHIP:_____
CONTACT NUMBER:_____

Medical Information

Have you suffered any serious injuries, or do you have any medical conditions or disabilities that may restrict your involvement in receiving services at our office?
□ NO □ YES
Describe:_____

Do you currently take any medications – over the counter or prescribed – on a regular basis?
□ NO □ YES
List:_____

Are you allergic to any medications or environmental substances?
□ No Known Allergies □ YES
List:_____

How frequently do you consume alcohol or use illicit substances (e.g. marijuana, hallucinogens, stimulants, opiates)?
Note substance and frequency of use:_____

Have you ever been hospitalized (include hospitalizations for medical reasons as well as mental health or drug/alcohol detoxification)?
□ NO □ YES
List reason/dates:_____

Do you suffer from any chronic medical conditions?
□ NO □ YES
Describe:_____

What is your current weight:_____ height:_____? (We ask these questions for the purposes of monitoring your weight as recommended by the American Psychiatric Association, the American Diabetes Association, the American Association of Clinical Endocrinologists and the North American Association for the Study of Obesity.)

Do you have an Advanced Directive for Mental Health (A legal document that outlines pre-established plan for mental health care if you are unable)? □YES _____ □ NO
For more information please visit http://www.nrc-pad.org/

Methodist Services Community Counseling

INSURANCE AUTHORIZATION

SIGNATURE ON FILE

CLIENT'S NAME:_____ **POLICY HOLDER'S NAME:**_____

PRIMARY INSURANCE:_____ **SECONDARY INSURANCE:**_____

PLEASE INITIAL

➢

_____ I authorize use of this form on all my insurance/third-party payer submissions

_____ I authorize release of information to my insurance carrier/third-party payer as necessary for billing and auditing

_____ I authorize my provider to act as my agent in helping me obtain payment from my insurance carrier or third-party payer

_____ I authorize payment directly to my provider

_____ I permit a copy of this authorization to be used in place of the original

_____ I authorize the performance of online/internet billing

_____ _____

CLIENT DATE

_____ _____

PARENT/GUARDIAN DATE

Methodist Services Community Counseling

NOTICE OF PRIVACY PRACTICES

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

MSvcs-CCS has a legal duty to safeguard your protected health information (PHI). PHI includes information that can be used to identify you, that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post the new notice in the appropriate areas.

"Protected health information" includes:

1. Your health history and medical records
2. Your name, address, date of birth, sex and marital status
3. Social Security number
4. Information regarding your dependents
5. Other similar information that relates to past, present or future medical care

Uses and Disclosure of Your Protected Health Information

Your protected health information may be disclosed to healthcare providers including doctors, nurses, psychiatrists, psychologists and other healthcare personnel involved in your treatment. We may also use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. In addition, your PHI may be used and disclosed for plan operation purposes including underwriting, premium rating, submitting claims for stop-loss coverage, quality review assessments, audits, business planning, legal services and other adjudication procedures. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

Non-Routine Uses of Your Protected Health Information

In situations not covered by your consent, your therapist will request authorization to use or disclose your protected health information. Your therapist will use or disclose information in these circumstances pursuant to the specific purposes contained in your authorization and will only disclose the minimum amount of information necessary to perform the non-routine function. In some circumstances, authorization may be obtained from a person representing your interests (e.g., if you are too incapacitated) or in emergency situations where authorization would be impractical to obtain.

Examples of Non-routine disclosures include the following instances:

1. When a disclosure is required by Federal, State, or local Law, Judicial or Administrative Proceedings, or Law Enforcement.
2. For Health Oversight Activities
3. For Public Health Activities
4. To Avoid Harm
5. For Specific Government Functions (e.g. national security purposes)
6. For Workers' Compensation Purposes
7. Correctional Institutions if you are an inmate
8. Appointment Reminders and Health Related Benefits or Services

Your Rights with Regard to Your Protected Health Information

1. To review protected health information maintained by our office and to obtain a copy of this information
2. To request amendments to your protected health information
3. To request an accounting of disclosures of your protected health information
4. To request restrictions on the protected health information that may be disclosed
5. To request communication regarding your protected health information from your therapist to be made at a certain time (all reasonable requests will be accommodated if made in writing)
6. To complain about our privacy practices
   If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may file a complaint with the Administrator of Community Counseling Services. You also may send a letter of complaint to the office of Northampton County Mental Health located at 2801 Emrick Boulevard, Bethlehem, PA 18020 or the PA Department of Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

By signing below,

- ✓ I acknowledge receipt of this notice of privacy practices and I acknowledge that I have had the opportunity to read this notice and to ask questions regarding the privacy practices of MSvcs– CCS.

_____ _____

CLIENT DATE

_____ _____

PARENT/GUARDIAN/AUTH REP DATE

Methodist Services Community Counseling

STATEMENT OF CLIENT'S RIGHTS

- Clients have the right to dignity and respect.
- Clients have the right to fair treatment. This is regardless of their race, religion, gender, sexual orientation ethnicity, age, disability or source of payment.
- Clients have the right to have their treatment and other client information kept private. Only by law, may records be released without client permission.
- Clients have the right to easily access care in a timely fashion.
- Clients have the right to know all about their treatment choices, and to have the option of requesting certain preferences in a provider. This is regardless of cost or coverage by the clients benefit plan.
- Clients have the right to share in developing their plan of care which includes having providers make decisions about their care on the basis of treatment needs. Clients also have a right to know which staff members are responsible for managing their services and in turn who they need to speak to about requesting changes.
- Clients have a right to have a clear explanation of their treatment options in a language they understand. Translation services are available as requested.
- Clients have a right to have a clear explanation of their condition.
- Clients have the right to get information about their insurance company's services and role in treatment process.
- Clients have the right to know the clinical guidelines used in providing and managing their clinical care.
- Clients have the right to information about provider work history and training.
- Clients have the right to provide input on their insurance company's policies and services.
- Clients have the right to know about advocacy and community groups and prevention services.
- Clients have the right to freely file a complaint, grievance or appeal and to learn how to do so (SEE BELOW)
- Clients have the right to know about laws that relate to their rights and responsibilities.
- Clients have the right to know of their rights and responsibilities in the treatment process.
- Clients have the right to review and correct records. *Note: Clients may request to have a copy of their clinical records. Record requests must be made in writing. In accordance with federal/state law, CCS does charge clients for these copies.
- Clients have a right to decline participation and withdraw from treatment.

STATEMENT OF CLIENT'S RESPONSIBILITIES

- Clients have the responsibility to treat those giving them care with dignity and respect.
- Clients have the responsibility to give providers information they need, so that providers deliver the best possible care.
- Clients have the responsibility to ask their providers questions about their care, so that they can understand their care and their role in that care.
- Clients have the responsibility to follow treatment plans for their care, once the plan is agreed upon by client and provider.
- Clients have the responsibility to follow their agreed upon medication plan.
- Clients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Clients have the responsibility to keep their appointments and clients should call their providers as soon as possible if they need to cancel visits.
- Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Clients have the responsibility to let their provider know about problems with paying fees.
- Clients have the responsibility of informing MSvcs-CCS of changes to their insurance or payment arrangements.
- Clients have the responsibility to not take actions that could harm themselves or others.
- Clients have the responsibility to report abuse or fraud
- Clients have the responsibility to openly report concerns about quality of care.
- Clients have the responsibility to notify their insurance company (when applicable) and to let their provider know if they decide to withdraw from services.

Clients who wish to express a grievance must request "client grievance form" from office staff and, after documenting specific grievance, forward that form back to the office staff for review by Administrator. After review of grievance, client will be contacted by Administrator.

_____ _____

CLIENT DATE

_____ _____

PARENT/GUARDIAN/AUTHORIZED REP DATE

Methodist Services Community Counseling
51 Market Street, Bangor PA 18013 Phone: 610-588-9109 Fax: 610-588-5016
1555 Northampton St. Easton PA 18042 Phone: 610-252-2000 Fax: 610-252-1484

PERMISSION TO CONTACT PRIMARY CARE PHYSICIAN (PCP)

We strive to assist you in achieving your goals for wellness. Communication between your behavioral health provider(s) and your primary care physician is important for comprehensive and well-coordinated care. This form allows us to share valuable information with your PCP. No information will be released without your signed authorization.

I_____(with the date of birth of _____)
do hereby consent to and authorize Community Counseling Services to:
____Release information to: _____Obtain information from:

My primary care physician:_____

Address:_____

Telephone:_____ Fax:_____

The information to be released includes:

____ Psychiatric Evaluation ____Medication Record ____ Bio-Psycho-Social Evaluation
____Treatment Plan ____ Therapy Summary ____Discharge Summary ____Psychiatric Notes

Please Initial:
_____ I authorize the release of my records understanding that they may include personal information pertaining to Drug abuse, Alcoholism, and or other substance abuse.
_____ I authorize the release of my records understanding that they may indicate the presence of a communicable or non-communicable disease such as HIV/AIDS.
_____ I authorize the faxing of my records.

I am authorizing this release of records for the purpose of:
____To coordinate treatment efforts with my PCP
____Other: _____

This authorization shall be effective immediately and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it and, if not revoked in writing, will terminate in **one year from today**. I have been informed of my rights, subject to Title 5100 of the Pennsylvania Mental Health Procedures Act to inspect material to be released and of the confidentiality provisions of the Pennsylvania Drug & Alcohol Abuse Control Act and the HIV-Related Information Act if this pertains.

This form has been fully explained to me. I understand its contents and I have been offered a copy.

Copy Offered:____Accepted ____Declined

_____ _____
Client Date

_____ _____
Parent/Guardian Signature/Auth Rep Date

_____ _____
Witness to Signature Date

Note: This information has been disclosed to you from records whose confidentiality is protected by state law. State regulations limit your right to make any further disclosure without prior written consent of the person to whom it pertains.

I DO NOT authorize the release of any information about my treatment to my primary care practitioner.

Client:_____ Date:_____

Parent/Guardian/Auth Rep:_____ Date:_____

Methodist Services Community Counseling
51 Market Street, Bangor PA 18013 Phone: 610-588-9109 Fax: 610-588-5016
1555 Northampton St. Easton PA 18042 Phone: 610-252-2000 Fax: 610-252-1484

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

I_____(with the date of birth of _____)
do hereby consent to and authorize Community Counseling Services to:

____Release information to: _____Obtain information from:

Person/Organization:_____

Relationship to Client:_____

Address:_____

Telephone:_____ Fax:_____

The information to be released includes:

____ Psychiatric Evaluation ____Medication Record ____ Bio-Psycho-Social Evaluation
____Treatment Plan ____ Therapy Summary ____Discharge Summary ____Psychiatric Notes

Please Initial
_____ I authorize the release of my records understanding that they may include personal information pertaining to Drug abuse, Alcoholism, and or other substance abuse.
_____ I authorize the release of my records understanding that they may indicate the presence of a communicable or non-communicable disease such as HIV/AIDS.
_____ I authorize the faxing of my records.

I am authorizing this release of records for the purpose of:

____To coordinate treatment with other service providers
____To obtain insurance, employment or government benefits
____To enable judges, attorneys, probation/parole officers to support treatment goals or to make legal decisions on my behalf
____To coordinate treatment efforts with my family and other concerned persons
____Other: _____

This authorization shall be effective immediately and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it and, if not revoked in writing, will terminate in **one year from today**. I have been informed of my rights, subject to Title 5100 of the Pennsylvania Mental Health Procedures Act to inspect material to be released and of the confidentiality provisions of the Pennsylvania Drug & Alcohol Abuse Control Act and the HIV-Related Information Act if this pertains.

This form has been fully explained to me. I understand its contents, and I have been offered a copy.

Copy Offered:____Accepted ____Declined

_____ _____
Client Date

_____ _____
Parent/Guardian Signature/Auth Rep Date

_____ _____
Witness to Signature Date

Note: This information has been disclosed to you from records whose confidentiality is protected by state law. State regulations limit your right to make any further disclosure without prior written consent of the person to whom it pertains.