Baker Street
Behavioral Health

New Client Intake

In an effort to keep our records current, we kindly request once you complete this form, PROVIDE US WITH A COPY OF YOUR INSURANCE CARD. Your understanding and cooperation is greatly appreciated.

CLIENT INFORMATION

Name:	DOB:	Gender: M F
Address:		
City:	State:	Zip Code:
Cell #:	Alternate #:	
Email Address:		

INSURANCE INFORMATION

Name of Primary Insured:	DOB:	Gender: M F
Mailing Address:		
City:	State:	Zip Code:
Cell #:	Alternate #:	
Email Address:		
Client Relationship to Insured: Self Spouse Child Partner Parent Other		
Insurance Company:		
Plan ID #:	Group #:	
Address:		
City:	State:	Zip Code:
Phone:		
Secondary: Yes No	Medicare: Yes No	Medicaid: Yes No

EMERGENCY CONTACT

Name:	Relationship:	
Address:		
City:	State:	Zip Code:
Cell #:	Alternate #:	
Email Address:		

YOU ARE RESPONSIBLE FOR UNDERSTANDING YOUR COVERAGE

Bring your insurance card with you to each office visit. It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, deductibles, limitations and authorization requirements. If your plan or insurance coverage changes and/ or you are issued a new card, it is your responsibility to notify us immediately. We are not responsible for charges that are denied because we have relied on information that is not current. In the event a claim is denied, you will be personally responsible for your bill and/or any outstanding charges.

INSURANCE COVERAGE

Baker Street Behavioral Health is an Out of Network provider. As a courtesy, we attempt to verify that your coverage is active and verify your Out of Network, Mental Health benefits before your first appointment with our office. However, you are responsible for finding out all information regarding your out of network coverage prior to your appointment. You are responsible for satisfying the out of network deductible. The deductible is determined by your individual contract with your insurance carrier. Co-insurance fees are your responsibility. Your insurance company expects co-insurance fees be collected at time of service.

Select insurance companies send reimbursement checks directly to the patient/ insured for services rendered by Baker Street Behavioral Health. Any reimbursement sent directly to the insured for services rendered by our doctors or clinicians must be remitted to Baker Street Behavioral Health within 14 days of receipt. Failure to do so will result in Baker Street Behavioral Health charging the credit card on file the reimbursement amount.

SELF PAYS

All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel at the start of your visit.

CANCELLATION POLICY

The time we set aside for your appointment is important and affects our efforts to efficiently serve all of our patients. If you are unable to keep your appointment you must provide us with notice at least 24 hours in advance of your appointment. Failure to give the required 24-hour notice will result in you being charged a $75.00 cancellation fee. This fee cannot be billed to your insurance company and will be your direct responsibility. Please call Baker Street Behavioral Health at 201-381-6136 with cancellation.

PAYMENT POLICY

Baker Street Behavioral Health will attempt to verify your Out of Network benefits and submit claims to your insurance carrier directly, as an out-of-network provider. However, it is your responsibility to meet your annual out of network deductible, as well as pay the co-insurance fee at the time of service. All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self pay patients. All self-pay patients are required to pay at the time service is rendered.

Check Policy:
When you use a check to pay for our services, you authorize us to represent your check to your bank for collection either electronically or by paper draft. In the event your check is returned for any reason, you understand you will be charged for any additional applicable fees as permitted by law.

Credit Card Policy:
Baker Street Behavioral Health requires a credit card on file for the select insurance companies who send the reimbursement checks directly to the patien/insured for services rendered by Baker Street Behavioral Health. Baker Street Behavioral Health requires the insurance reimbursement that is issued by the insurance provider for services rendered by Baker Street Behavioral Health be remitted to our office within 14 days of receipt of the check or the credit card on file will be charged. In addition, Baker Street Behavioral Health reserves the right to charge the credit card on file for any applicable deductible or co-insurance fees or if you are not in compliance with the cancellation policies.

If Your Account Becomes Delinquent:
We will do our very best to work with you. Our billing office may contact you by telephone, email and/or by mail. If you do not respond to our attempts to discuss your balance we may refer your account to an outside collection agency. Once your account has left our office for collections, we can no longer communicate with you regarding your balance and you must address your circumstances with the agency. You will also be directly responsible for any additional fees associated with the collection of your balance. You should also be aware that referral of your balance to a collection agent may constitute grounds for your discharge from the practice.

If you have any questions regarding our guideline please feel free to contact our Billing Department at 201-381-6136.

Your signature below acknowledges that you have read, understood our policies and your responsibility regarding the charges and fees that you have incurred as a result of services that you have received from Baker Street Behavioral Health.

Name of Patient: ______________________________

Date: ______________________________

Name of Patient/Guardian: ______________________________

Signature of Patient/Guardian: ______________________________

Date: ______________________________

Financial Service Guidelines

Credit Card Information

Name on Card: ______________________________ EXP Date: ______________

Credit Card #: ______________________________ CVV: ______________

Visa MasterCard American Express Discover Billing Zip Code: ______________

FSA Card: Yes No SuperBill Needed: Yes No

Please initial:

_________ I understand Baker Street Behavioral Health reserves the right to charge my credit card for any applicable deductible or coinsurance fees should payment not be made at the time of the appointment.

_________ I understand Baker Street Behavioral Health reserves the right to charge my credit card if I am not in compliance with the cancellation policy.

_________ I understand as a member of an insurance provider that reimburses the insured rather than the provider rendering the service, Baker Street Behavioral Health reserves the right to charge my credit card the reimbursement payment issued by the insurance provider if the reimbursement check is not brought to Baker Street Behavioral Health within 14 days of receipt of the payment. In the event Baker Street Behavioral Health charges my credit the reimbursement payment, the member can then keep the check issued by the insurance provider.

_________ I understand Baker Street Behavioral Health reserves the right to pass on any applicable chargeback fees pennitted by law associated with a disputed credit card charge.

_________ I understand failure to comply with our policies may result in pause in services until your account is made current. Baker Street Behavioral Health, however, reserves the right to terminate services and forward the account to Collections if necessary

Name of Patient: ______________________________ Date: ______________

Name of Patient/Guardian: ______________________________

Signature of Patient/Guardian: ______________________________ Date: ______________

Baker Street
Behavioral Health

Client Consent to Treatment

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the initial evaluation fee and agreed upon session fees. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with ______________________________________ I know I can end therapy at any time i wish and that I can refuse any requests or suggestions made by ______________________________ I am over the age of eighteen.

Client: ______________________________ Date: ______________________________

Witness: ______________________________ Date: ______________________________

Consent for Treatment of Minors

I/We____________________________________ have full custodial guardianship of my child ____________________________. He/she is currently under the age of 18, and I/we consent that he/she may be treated as a client by
_________________________________.

Parent/Guardian Name: ______________________________

Client Assent (if over the age of 14): ______________________________ Date: ______________________________

Witness: ______________________________ Date: ______________________________

Parents: Do not leave the office while your minor child is with his/her therapist. You must provide a responsible adult who is to be present during your child's visit. It is not the staffs responsibility. In addition, it may be necessary for the therapist to speak with you at some point with you at some point during your child's session.

Verification Statement of Therapist

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the parent's or guardian's mental capacity and found her or him capable of giving an informed consent at this time.

Initial of Therapist: ____________ Date: ______________________________

Baker Street
Behavioral Health

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy containing a more complete description of the uses and disclosures of my health information {available in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

____

Patient's Name & Date of Birth {MM/DD/YYYY)

____

Signed (Patient or Legal Representative for Patient)

____

Date

Baker Street
Behavioral Health

Authorization of Release of Information

I / We ______________________________

Client Name/Parent or Guardian Name

hereby authorize Baker Street Behavioral Health/ ______________________________

Clinician Name

To:

Release information to: Name: ______________________________

Obtain information from: Phone: ______________________________

Exchange information with: Fax: ______________________________

The information requested or authorized for release or exchange pertains to:

Client Name: ______________________________

Clinical information pertaining to treatment:

Other: ______________________________

This authorization is valid through _____________ or indefinitely _________ (initial). I may revoke this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the clinician/group above indicating my desire to cancel. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I understand that my treatment provider generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

______________________________ ______________________________

Client's Signature (if over 14 years old) Date

______________________________ ______________________________

Parent/ Guardian's Signature Date

Baker Street
Behavioral Health

Telehealth Informed Consent for Assessment and Treatment

I, ____, hereby consent to participate in Telehealth with Baker Street Behavioral Health. I understand that Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

Electronic systems used will incorporate network and software security protocols and are HIPAA compliant to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

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 to future care, services, or program benefits to which I would otherwise be entitled.
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 the disclosure 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 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/emotional health 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 is 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 (201) 381-6136 to discuss possibly having to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

EMERGENCY PROTOCOLS

In case of an emergency your provider will need to know your location. You agree to inform me of the address where you are at the beginning of each session if different than listed below. A contact person who your provider may contact on your behalf in a life- threatening emergency only is also needed. This person will only be contacted in the event of an emergency.

In case of an emergency, my location is: ____

and my emergency contact person's name and phone: ____

EXPECTED BENEFITS OF TELEHEALTH

- Improved access to counseling care by enabling a client to remain in his/her home or office.
- More efficient psychological evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE LIMITATIONS OF TELEHEALTH

These limitations include, but may not be limited to:

- Potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors

I have read the information provided above and discussed it with my provider. I understand the information contained in this form and all of my questions have been answered to my satisfaction. I hereby give my informed consent with Baker Street Behavioral Health to use telepsychiatry and teletherapy in the course of my diagnosis and treatment.

Signature of client/parent/legal guardian ______________________ Date ______________________

Signature of therapist/prescriber ______________________ Date ______________________