Hope Enrichment Center, PC

7300 W. College Dr. Suite 203
Palos Heights, IL 60463

6858 Swinnea Rd, Building 7,
Southaven, MS 38671

304 Enterprise Dr
Oxford, MS 38655

5545 Murray Ave Suite 204
Memphis, TN 38119

806 S. Parkway Rd.
Corinth, MS 38834

WELCOME to Hope Enrichment Center! Please complete the following information prior to your first appointment. This will help us to better serve you! As you answer the questions, if you have any questions or concerns, please feel free to ask your therapist.

Today I am here to see: **Date:** _____

Provider Name:_____ **Location:** _____

SECTION 1 – Contact information

CLIENT NAME First: MI: Last:	**DATE OF BIRTH** **Age**
MAILING ADDRESS STREET: CITY/ STATE: ZIP:	
PREFERRED PHONE # TYPE: ☐ HOME ☐ MOBILE ☐ OTHER	**MAY WE LEAVE A MESSAGE**: ☐ YES ☐ NO **MAY WE SEND A TEXT MESSAGE:** ☐ YES ☐ NO
EMAIL ADDRESS	**EMPLOYER/SCHOOL NAME**
MARITAL STATUS ☐MARRIED ☐ DIVORCED ⬜ SINGLE ☐SEPARATED ☐ WIDOW	**OCCUPATION/JOB POSITION**
GENDER:	**PREFERRED NAME:**
EMERGENCY CONTACT **NAME:** **RELATIONSHIP:** **PHONE NUMBER:**	
RELEASE OF INFORMATION SIGNED FOR EMERGENCY CONTACT: ⬜ **YES** ⬜ **NO** * **if you have a medical emergency while you are in our office***	**MAY WE SEND MAIL TO YOUR HOME:** ☐ YES ☐NO (*All mail comes from "HEC" discreetly)*

If the client is a minor, please complete the following information.

WHO DOES MINOR RESIDE WITH?	**NAME OF RESPONSIBLE PARTY**
RELATIONSHIP TO CLIENT	**NAME OF SCHOOL/CURRENT GRADE**
ADDRESS	**CITY** **ZIP**
PREFERRED PHONE # TYPE: ☐ HOME ☐ MOBILE ☐ OTHER	**MAY WE LEAVE A MESSAGE**: ☐ YES ☐ NO

SECTION 2 - Referral Information

We appreciate our referral sources! May we inquire as to who/ what website referred you to our office?

_____

SECTION 3 – Fees for Services & Consent Agreement

Primary Insurance Carrier Information

☐ **Self – Pay client** (no insurance will be used).

In order to provide our clients with the highest level of care, we refrain from engaging in contracts with private insurance carriers that can dictate treatment and compromise private health information. Payment for services are due *at the time of* services in the form of cash, personal check, or charge.

NAME OF INSURED (Name on insurance card)	**DATE OF BIRTH**
SUBSCRIBER/ MEMBER ID #	**POLICY # (if applicable)** **GROUP # (if applicable)**
NAME OF INSURANCE CO.	**PHONE #**
ADDRESS OF INSURANCE CO.	**CITY** **STATE** **ZIP**

Has your deductible been met? ☐ Yes ☐ No ☐ Does not apply ***If you are unsure if you have met your deductible or if it applies, please refer to the customer service number on the back of your insurance card and call your insurance company.***

Are you using EAP? Authorization # _____ Number of Sessions: _____

Claims Address: _____

 Filing for Secondary Insurance is the client's responsibility.

Hope Enrichment Center will assist our clients wishing to obtaining reimbursement from their private insurance carriers by:

-Creating receipts for services with the information required by most insurance carriers for reimbursement.

-Creating a super bill on a monthly or quarterly basis.
-Answering questions regarding insurance forms and procedures.

CONSENT AGREEMENT – PAYMENT FOR SERVICES

Your insurance coverage is an agreement between you and your insurance company. The consumer (or the Responsible Party listed in the Minor's section) is ultimately responsible for any and all expenses incurred for treatment at the Hope Enrichment Center PC. We will file all claims for the services rendered at the Hope Enrichment Center, PC with your primary insurance carrier. If your insurance carrier does not pay its portion within 4 weeks of the filing date, and we have done everything in our power to effectively obtain payment for services, the consumer is ultimately responsible for your service fees. We will be diligent in communicating any insurance reimbursement difficulties with the consumer as this information becomes apparent to our billing department. I hereby authorize Hope Enrichment Center, PC. to release any information required in the processing of claims. I acknowledge and agree that the Hope Enrichment Center, PC has permission to send my case to a third- party collection agency in the event that I neglect to pay for services in a timely fashion.

I understand that the cost per clinical hour is $250.00 for the Initial Evaluation, and $200.00 for any follow-up sessions. Discounted self-pay rates are offered for services received by pre-licensed clinicians (see Fees/payment in General Office Policies)

In the event a credit is developed on your account (Less than $50.00), we will automatically apply said credit to future co-payments/co-insurance costs or your deductible. Consumers may request to receive their account credit back in the form of a check from the Hope Enrichment Center PC. This request for a credit must be done in writing and submitted to the Hope Enrichment Center PC billing department. The Hope Enrichment Center PC has up to 30 business days after the request is submitted for said credit to be returned to the consumer.

I understand that the **full 1 hour session amount will be charged for failed appointments** (i.e. not canceling your appointment with 24-hour notice or failing your scheduled appointment time). Discounted fees apply to discounted services received by pre-licensed clinicians (see Fees/payment in General Office Policies).

There will be a 3% fee for payments with credit card and a $30.00 charge for returned checks. Payment is due upon receipt of services. I also attest that I have received and read the General Policy Statement.

Signature of responsible party:_____ **Date:**_____

SECTION 4 – What brings you in today?

Have you had -

☐ Frequent mood changes	☐ Depression	☐ Anxiety/ Worry	
☐ Change in sleep patterns	☐ Change in appetite	☐ Panic attacks	☐ Difficulty focusing
☐ Feel overwhelmed	☐ Crying spells	☐ Low motivation	☐ Racing thoughts
☐ Nightmares	☐ Irritability	☐ Self injury	☐ Acting out/impulsivity
☐ Increased substance use	☐ Thoughts to harm self	☐ Thoughts to harm others	
☐ Other:			

_____

Recent stressors – (last 12 months)

☐ Marital issues	☐ Divorce/Separation	☐ Relationship conflict	☐ Remarriage
☐ Pregnancy/Miscarriage	☐ Sexual identity issues	☐ Infertility	☐ Parenting
☐ Major life transition	☐ Health/Medical issues	☐ Financial stress	☐ Traumatic event
☐ Loss of a loved one	☐ Issues at work/school	☐ Identity issues	☐ Aging parents
☐ Spiritual issues	☐ Legal issue	☐ Hospitalized for mental health or substance use	
☐ Other: _____			

Health review – (last 4 weeks)

☐ Feel tired	☐ Feel like you are running on a motor	☐ Nausea	
☐ Oversleeping	☐ Sleep disturbance	☐ Hot or cold spells	
☐ Increase in weight	☐ Decrease in weight	☐ Headaches	
☐ Rapid pulse	☐ Chest pain	☐ Cardiac issue	☐Diarrhea/Constipation
☐ Decreased sex drive	⬜ Hair loss		
☐ Vomiting	☐ Broken bone/sprain/strain	⬜ Shortness of breath	
☐ Sexual performance concern		⬜ Cancer	
☐ Surgery	⬜ Difficulty recovering after pregnancy	⬜ Excessive sweating	
☐ Hospitalization	⬜ Missed menstrual period	⬜ Aches/pain	
☐ Other:			

_____

Primary Healthcare Physician (PHP): _____

Last visit: _____

Physician's address & phone number:

_____

Release of Information for Primary Care Physician signed: YES NO Date Signed:_____

☐ **No Primary Health Physician**

SECTION 5 – Confidentiality and General Policy Statement

PLEASE REVIEW AND INITIAL BOTH PARTS.

Confidentiality and Privacy Policy

All sessions are confidential according to Mississippi, Tennessee, Illinois, and federal law. However, we have a duty to prevent harm to you and others. Therefore, we are required by law to respond responsibly. Laws require us to report suspicion of child or elder abuse to either the Department of Children and Family Services or the Department of Aging.

We are also required to secure adequate care of those struggling with suicidal or homicidal thoughts and behaviors. If you have specific questions, please discuss them with your counselor.

In some circumstances, mental health records and information may be subpoenaed for legal purposes. Please inform your counselor of any legal issues IMMEDIATELY and consult with your attorney for counsel on receiving mental health services. *A full explanation of our Privacy Policy and Legal Fees are available to you upon request and you are encouraged to review it if you have any questions or concerns regarding your confidentiality rights.*

INITIALS _____

General Office Policies

 APPOINTMENTS – Each clinician at the Hope Enrichment Center, PC is responsible for making their own appointments. Please consult with your individual therapist to both obtain and reschedule all appointments.

 SOCIAL MEDIA POLICY – Hope Enrichment Center, PC asks that you agree to review and sign our *Social Media Policy* to ensure the highest level of ethical communication possible regarding your private health information.

 CANCELATION POLICY – Hope Enrichment Center, PC asks that you respect our 24-hour cancelation policy. If you are in need of rescheduling or canceling an appointment, please provide your counselor with a 24-hour notice. This allows your therapist to place another client into that time slot and adjust their daily schedule accordingly. There is a **$150.00- $75.00 fee (**amount of the full hour session) for same day cancellations (less than 24-hour notice) and failed scheduled appointments. This fee is charged to your card on file, is due at your next scheduled session, or within thirty (30) days of the failed appointment. ***In signing this document, you are acknowledging your agreement with this policy.***

 AFTER-HOURS or EMERGENCY NEEDS – Hope Enrichment Center staff is NOT on 24 hour call for clinical assistance or emergencies. Hope Enrichment Center office hours are Monday – Thursday 8:30 am – 5:00 pm; Fridays and Saturdays are by appointment only. We are happy to return calls during regular business hours. Hope Enrichment Center staff agrees to do its best to address psychiatric emergencies during its regular business hours however, it cannot guarantee immediate response. Therefore, if you experience a psychiatric emergency you are encouraged to call 800-273-8255, a 24 hour hotline, or 9-1-1.

 FEES/PAYMENTS – Payment for services are due at the time of services in the form of cash, personal check, charge, or bank debit. Our fees are delineated by clinician licensure type:

For fully licensed clinicians or able to utilize insurance benefits:
Initial Assessment: $250.00
Follow-up 60 min Sessions: $200.00
30 min Sessions: $100.00

Cash Rates for Temporarily Licensed clinicians:
IL- $95.00 per clinical hour/$75.00 per 30 min session
MS/TN - $75.00 per clinical hour/$50.00 per 30 min session

Cash Rates for Senior Temporarily Licensed clinicians:
IL - $95.00 per clinical hour/$75.00 per 30 min session
MS/TN - $85.00 per clinical hour/$50.00 per 30 min session

Cash Rates for Interns:
IL/MS/TN - $50.00 per clinical hour/$35.00 per 30 min session

 MEDICATIONS – The staff at the Hope Enrichment Center, other than Oxford Location, does not prescribe medications of any type. However, if you are in need of such services, we will be happy to refer you to a competent physician who can provide you with medication management.

INITIALS : _____

CONSENT FOR TREATMENT

The type of psychological treatment that you will be receiving is based on the research findings regarding the optimal methods of helping people effectively cope with and/or overcome a wide range of mental health conditions. The mental health conditions are described in detail in the Diagnostic and Statistical Manual of Mental Health Disorders – Fifth Edition (DSM-V). The specifics of your diagnosis will be discussed with you prior to your beginning treatment. Before beginning psychological treatment, a mental health history will be taken during an interview or interviews with your Hope Enrichment Center clinician. In addition, prior diagnostic evaluations that are related to mental health will be reviewed. These evaluations may include, but are not limited to, medical reports regarding health conditions, neurological functioning, neuro-psychological and psychological skills, Speech-Language, Occupational Therapy, and prior mental health diagnoses and treatment. Your Hope Enrichment Center clinician will discuss your initial diagnosis and treatment plan with you to ensure your understanding of the plan and proposed treatment.

Hope Enrichment Center provides a variety of mental health treatments, including:

- Individual psychological counseling that is structured to meet the needs of the specific person. The counseling approach for each individual is specifically tailored to that person's mental health needs. Depending on an individual's needs, several approaches to counseling may be incorporated into treatment, including: Cognitive and Behavioral Therapies (CBT & DBT), psychodynamic approaches, relational therapy, cognitive restructuring techniques, EMDR (Eye Movement Desensitization and Reprocessing), mindfulness, art therapy, movement therapy, performance enhancement, biofeedback, and neurofeedback.
- Family counseling.
- Marital counseling.
- Group counseling.
- Consultation with other mental health providers, schools, and medical service providers *(with approved signature of release).*

I agree to the above Confidentiality, Privacy, and General Policies, as well as Consent for Treatment of the Hope Enrichment Center, P.C.

Client Signature: _____ Date:_____

I agree to communicate any and all changes in the above statements or policies of the Hope Enrichment Center, PC as they are established.

Therapist signature: _____ Date:_____

A copy of the Confidentiality, Privacy, General Policies, and Consent for Treatment can be provided to the client for their information upon request.

Emergency Contact

Release for Disclosure of Confidential Information

I,_____Born on,_____ authorize the release of
(Print Client's Full Name) (Date of Birth)
information regarding my ***current*** mental and physical health status to_____
(Printed name of emergency contact)
at (Emergency Contact's phone number) _____ in the event of an emergency.

An ***emergency*** is defined here as an event or situation in which the client named above is unable to adequately care for him/herself due to lack of consciousness, severe physical illness, or client self-report of suicidal/homicidal ideation. I understand that outside of these circumstances, the individual I have provided as my emergency contact will have NO access to my mental health records or treatment information at the Hope Enrichment Center, PC. (NOTE: *This agreement does **NOT** preclude Hope Enrichment Staff from also contacting the necessary authorities as deemed appropriate by state mandate or overall safety for the client, the Hope Enrichment Center staff, and those on the premises at the time of the event*.)

This consent shall expire automatically upon the fulfillment of the purpose stated herein. Additionally, this agreement will expire on _____, 20_____. I understand I have the option to renew this agreement after it has expired.

I hereby authorize the information described above to be released to the party identified on this form. I understand that this release is voluntary and I agree that I was free of pressure or influence from any person or entity upon signing this agreement.

_____ _____ _____
Signature of patient **Printed name of patient** **Date**

_____ _____ _____
Signature of Witness **Printed name of Witness** **Date**

Hope Enrichment Center Social Media Policy

FRIENDING ON SOCIAL MEDIA

Employees and consultants of the Hope Enrichment Center (HEC) do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). These sites may compromise your confidentiality and our respective privacy. It may also blur the boundaries of the therapeutic relationship

FANNING AND FOLLOWING

The Hope Enrichment Center (HEC) has a Facebook Page for the practice at large to allow people to share our YouTube and blog posts. It also allows the public access to practice updates and events. All of the information shared on this page is available on our website as well. You are welcome to view our practice Facebook Page and read or share articles posted there. However, becoming a Facebook or blog "fan" creates a greater likelihood of compromised client confidentiality. NOTE: you are able to subscribe or follow a page via RSS without becoming a Fan and without creating a visible, public link to the HEC Page. You are more than welcome to do this.

INTERACTING ON SOCIAL MEDIA

Please refrain from using messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact any of the staff at HEC. These sites are not secure and we may not read these messages in a timely fashion. Refrain from using Wall postings, @replies, or other means of engaging with HEC staff or consultants in public online if you have an established client/therapist relationship. Engaging with HEC and its staff this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact HEC staff, the best way to do so is by phone at 708-448-7848 or direct email of staff at *www.hopeenrichmentcenter.com*.

LOCATION BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our offices on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from our offices or if you have a passive LBS app enabled on your phone.

EMAIL

Email is NOT a completely secure or confidential method of communication. For this reason, we ask that you take caution in emailing HEC Staff content related to yourself, your therapy sessions, or financial information. If you choose to communicate with any of the HEC staff by email, be aware that all emails are retained in the logs of your, and our, Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s). You should also know that any emails we receive from you, and any responses that we send to you, become a part of your legal record. HEC Staff respond to emails as they are able to do so. Therefore, we encourage you to refrain from reaching out to HEC Staff in an email format for immediate care. Please call 911 or go to your nearest emergency room.

TEXTING

Please be informed that any and all text messages that we receive from you, like emails, are a part of your legal medical record. If you choose to utilize text communication with HEC staff, we ask that you do so ONLY in regards to making/breaking appointments, appointment confirmation, or information about running late for an existing appointment. Clinicians and administrative staff are unable to respond immediately to text messages. If you communicate via text, you do so with the knowledge that the HEC staff will respond when they are available to do so during their stated hours of availability. Therefore, if you are experiencing a mental health emergency, you are encouraged to call 911 or go to your nearest emergency room.

Also know that text messages can reside on a mobile device indefinitely where your information can be exposed to third parties due to theft, loss, or recycling the phone. Text messages can also be accessed without any level of authentication. For these reasons, the information communicated via text will be unable to be protected by HEC and its staff.

BUSINESS REVIEW SITES

You may find our practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. If you should find our listing on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our client. The American Counseling Association's Ethics Code states that it is unethical for mental health professionals to solicit testimonials.

You have the right to express yourself on any site you wish. However, due to confidentiality, HEC and its staff cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your personal privacy as seriously as we take our commitment to keeping your personal information confidential. You are welcome to share that you are in therapy wherever and with whomever you like; in any forum of your choice. If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection

We here at HEC encourage you to bring your feelings and reactions about our work directly to us. If you feel any of the HEC staff have done something harmful or unethical, and you do not feel comfortable discussing it with us, you can always contact the *Tennessee State Board of Examiners for Licensed Professional Counselors*, which oversees licensing, and they will review the services we have provided.

TN Department of Health	MS State Board of Examiners for	**IL Dep of Financial and**
Division of Health Licensure & Regulation	Licensed Professional Counselor**s**	**Professional Regulation**
665 Mainstream Dr, 2nd Floor	239 North Lamar Street Suite 402	**100 West Randolph, 9th Floor**
Nashville, TN 37243	Jackson, MS 39201	**Chicago, IL 60601**
Office: 1-800-778-4123	Office: 601 359-1010	**Office: 1-888-473-4858**

If you have questions or concerns about any of these policies, please bring them to our attention.

****

I (print name), _____, have read, understand, and agree to comply with the Hope Enrichment Center's Social Media Policy.

_____ _____

Client Signature **Date**

_____ _____

Hope Enrichment Center Credit Card Authorization and Payment Agreement Form

Hope Enrichment Center (HEC) has implemented a policy which enables you to maintain your credit card information securely on file. In providing us with your credit card information, you are giving HEC permission to automatically charge your credit card on file for your co-pay, failed scheduled appointment fees, and any/all outstanding balances on your account [or any other patient(s) you have listed on this form] with HEC. By signing this agreement, you understand that this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request. **I understand a 3% CC fee will be charged for payments made by card.**

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize the Hope Enrichment Center, PC to charge co-pays, FSA charges and outstanding balances on my account to the following credit card:

Credit Card Holder's Name (as it appears on card): _____

☐ Visa ☐ Mastercard ☐ Discover

Card Number: _____/_____/_____/_____

Expiration Date: _____/_____ CCV#: _____ Billing Zip: _____ Address #: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Name(s) (print): _____

Card Holder's Signature: _____ Date: _____

I agree to notify Hope Enrichment Center (HEC) in writing of any and all changes on my account or my intention to terminate this authorization. I certify that I am an authorized user of this credit/debit card account and that I will not dispute these scheduled transactions with my card company, so long as these transactions correspond to the terms indicated in this authorization agreement. I understand that signing this form is voluntary and used for my convenience. I also agree that I am signing this agreement under no duress. This form has been updated as of January 2023

Legal Fees, Letter Writing, and Court Attendance/ Depositions

Under the Health Insurance Portability and Accountability Act (HIPAA), a covered entity can charge reasonable cost-based fees for providing medical records to patients (45 CFR 164.524(c)).

HEC's most recent regulations for legal fees and court actions are as follows:

- A charge of $25.00 per hour may be collected for administrative costs. In addition;
- A fee of $10.00 USD will be charged for certifying the medical records. In addition;
- The cost of postage will also be charged. In addition;

Fees for copying documents will be:

- $0.97 per page for the first 20 pages
- $0.83 per page for pages 21 through 100
- $0.66 for each page copied in excess of 100 pages

For **medical records** that are not in paper form, the provider shall be entitled to recover the full reasonable cost of reproduction with a minimum fee of $25.00 USD.

For **letter writing, treatment plan summaries, completion of forms for disability, etc.** HEC will charge a minimum of $50.00 and a maximum of $150.00 depending on time investment and document type.

Attendance in Court and Depositions

Clients are highly discouraged from having their therapist subpoenaed for a variety of reasons. Even though you are responsible for the testimony fee, it does not mean that HEC's clinicians' testimony will be solely in your favor. HEC can only testify to the facts of the case and to their professional opinion. Testimony will also allow for information previously protected by HIPAA laws to be eligible to be provided in open court.

For those desire to proceed with court or deposition attendance, the following fees are in effect:

- Preparation time (including submission of records): $200/hr
- Phone calls: $200/hr
- Depositions: $250/hour
- Time required in giving testimony: $250/hour
- Mileage: $0.55/mile
- Time away from office due to depositions or testimony: $200/hour
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- Filing a document with the court: $100
- The minimum charge for a court appearance: $1500

A retainer of $1500 is due in advance. **If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "express" charge (if the case is reset with less than 72 business hours notice, then the client will be charged $500 in addition to the retainer of $1500).**

Finally, all fees are doubled if the HEC clinicians had scheduled plans to be away from the office or on vacation.

In signing this document, you are acknowledging your agreement with this policy.

Client Signature: _____ Date:_____

Witness Signature: _____ Date:_____