Ho'olilo Counseling, LLC

Pamela K. Silva, LCSW, QCSW

Welcome To Our Practice

Patient Registration

Patient Name: ______________________ **Date of Birth:** ______________
Social Security #: ______________________ **Sex:** ☐ **Male** ☐ **Female**
Address: ____
City: ______________ **State:** __________ **Zip Code:** ____________
Home Phone: ______________ **Cell/Other Phone:** ______________________
Are you a student: ☐ Full-time ☐ Part-time ☐ Not a student **Grade:** _____ **School:** ____________
Ethinicity: ______________ **Preferred Language:** ________ **Race:** ____________
Referred by: ______________________________

Guarantor: ______________________ **Phone:** ______________________
Employer: ____
Relation to patient: ______________________________________

Primary Insurance Information:
Insurance Company: ______________________ **Policy Holder's Name:** ____________
Policy Holder's Date of Birth: ______________ **Policy Holder's SSN:** _____-_____-_______
Policy #: ______________________ **Group #:** ______________
Relationship to Patient: ______________________ **Employer:** ______________

Secondary Insurance Information: ☐☐ **Check here if no secondary insurance**
Insurance Company: ______________________ **Policy Holder's Name:** ____________
Policy Holder's Date of Birth: ______________ **Policy Holder's SSN:** _____-_____-_______
Policy #: ______________________ **Group #:** ______________
Relationship to Patient: ______________________ **Employer:** ______________

Emergency Contact:
Name: ______________________________ **Relation to Patient:** ____________
Address: ____
City: ______________ **State:** __________ **Zip Code:** ____________
Home Phone: ______________ **Cell/Other Phone:** ______________________

Assignment and Release:
I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to HO'OLILO COUNSELING, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I/We hereby state that the information above is true and correct to the best of my/our knowledge.

The above named physician may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one-year from the date signed below.

____ ______________
SIGNATURE OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT DATE

____ ______________
PRINT NAME OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT RELATION TO PT

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Child / Adolescent Intake Information

(To be completed by Parent or Legal Guardian)

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for treatment.

Date:____________________

Patient's Name:____

Address:____ City:______________ Zip:________

Home Phone:____________________ Cell Phone:_______________ Email:___________________

Child/Adolescent's Birth Date:__________________________ Age:_______ Sex:_____________

Referred by:_____________________ Address:____

Parent or Guardian Living with child/adolescent

Name:____

Occupation:___________________________ Employer:_________________________________

Work Phone:____________________ Cell Phone:_______________ Email:___________________

Spouse/Partner:____

Occupation:___________________________ Employer:_________________________________

Work Phone:____________________ Cell Phone:_______________ Email:___________________

Siblings (include biological, adopted, foster, step, etc.):

Name:	Sex:	Age:	Type (bio, step, etc.):	Custody?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

Is there any other person living in your household other than parents or siblings? ☐ YES ☐ NO
If yes, please give their name/s and their relationship to you.

____

____

____

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Patient's Mother's Maiden Name: ____________________

Are biological parents divorced or separated? ☐ YES ☐ NO If yes, for how long?____________

If parents are divorced provide name, address, and telephone number of biological parent not in household.

____

Does non- custodial parent share joint custody? ☐ YES ☐ NO Eplain:____________

COUNSELING HISTORY OF CHILD/ADOLESCENT
From:__________ To:__________ With Whom?____________

For What?____________________

BASIC HEALTH: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last Physical Exam?__________

Who is your Physician?____________________Ph:____________

Is child/adolescent taking any prescription medication at this time? ☐ YES ☐ NO

If yes, what?____________________

Is child/adolescent taking any over the counter medication? ☐ YES ☐ NO

If yes, What?____________________

Is child/adolescent taking any medication for allergies? ☐ YES ☐ NO

If yes, What?____________________

Are there any physical, emotional, or mental conditions now or in the past that I need to be aware of?
☐ YES ☐ NO
If yes, What?____________________

Has child/adolescent ever been hospitalized? ☐ YES ☐ NO

If so, for What?____________________ How long?____________

CURRENT REASON FOR SEEKING COUNSELING:
Briefly describe the problem for which you wish your child/adolescent to have counseling?

____

____

What would you like to see happen as a result of counseling?

____

How would you describe your spiritual or religious beliefs?____________________

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The thing which concerns me the most right now is?

Assertiveness	Health problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Bedwetting	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Energy	Sleep	Decision making
Physical abuse	Children	Parents	Insomnia
Education	Divorce	Relaxation	Ambition
Anger/Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug Use	Headaches	Tiredness
Headaches	Finances	Appetite	School
Unhappiness	Fears	Work	Confusion
Premarital	Food	Self-control	Sadness
In-laws	My past	Guilt	Anxiety

Other:

____

____

____

____

Now put an * by the items that are causing you the MOST difficulty.

IT IS CUSTOMARY TO PAY YOUR THERAPIST AFTER EACH SESSION.
* A Counseling Session is normally ____ minutes.

POLICY

A 24-HOUR CANCELLATION NOTICE IS APPRECIATED; OTHERWISE USUAL FEE WILL BE CHARGED.

I understand that suicidal threats, homicidal threats or child abuse by an adult to a child will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

Parent's Signature____

Child/Adolescent's Signature____

HO'OLILO COUNSELING LLC
94-1036 Waipio Uka Street, Ste. 109, Waipahu, HI 96797, (808) 292-0885

INFORMED CONSENT

1. You have the right to ask questions about any procedures used during therapy; if you desire, I will explain my approach and methods to you. If I see a child under the age of 18, custodial parents/guardians have a right to information shared in the session, though exercising this right may be detrimental to the therapeutic process, and so I may decide to allow confidentiality between the child and the Therapist.

2. You have the right to decide not to receive therapeutic assistance from me; if you desire, I will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone or in writing if you make such a decision without consulting me.

4. You have a right to review your records in the files. Please refer to the HIPAA handout for specific details.

5. One of the most important rights involves ***confidentiality:*** within limits of the HIPAA law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member or a couple is being seen in therapy, the Therapist views the family/couple as the client. Therefore, releases of information for family/couples' sessions require the written approval of every consenting member of the family/couple who was present at any time during the treatment.

6. If you request it, any part of your record in my file can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful to you in any way.

7. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: a) if you threaten grave or bodily harm or death to another person, I am required by law to disclose this information to the appropriate authority; b) If a court of law issues a legitimate Court Order (signed by a Judge), I am required by law to provide the information specifically described in that order; c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; d) If you are in therapy by order of a Court of law, the results of the treatment ordered must be revealed to the Court; and e) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).

8. You have the right to know about the possible harmful results of therapy. In my years of Psychotherapeutic service delivery and supervision, the only clear harm I have witnessed has resulted from clients' insistence on using medical insurance for psychotherapy. Harmful events included (but are not limited to): denial of insurability when applying for medical and disability insurance due to DSM-IV-TR or DSM-V diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurance); company (mis) control of information when claims are

processed; loss of confidentially due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness," including driver's licenses applications, concealed weapon permits, and job applications.

9. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family, marital and personal goals and values; that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from specific concerns brought to therapy. In working towards these potential benefits however, therapy will require that consistent efforts are made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

10. Please note that the quickest way to get ahold of me is by phone contact or e-mail. Voice messages will be returned at my earliest convenience.

11. You are required to keep me informed of any changes to your insurance. Having insurance does not necessitate payment and you will be financially responsible for any balances that your insurance does not cover.

FEES and Length of Therapy Sessions

1. If you are running late for your appointment, please phone me. Your appointment spot will be held for a period of 15 minutes. After that period, I reserve the right to cancel the spot and charge you for a missed session.

2. I do not automatically engage in participating in Court hearings or proceedings. There are special circumstances under which this may be discussed.

3. Session times normally last between 45 - 55 minutes, with the exception of the initial evaluation which generally lasts approximately one hour.

4. For after hour emergencies, please go to your nearest emergency room, contact the Crisis Hotline at (808) 832-3100 or call 911.

5. Forms of payment that are accepted are: Cash, Check or Charge. For any returned checks, a fee of $30.00 will be assessed.

6. If you miss two sessions in a row or consistently cancel scheduled sessions, I will not be obligated to schedule future appointments and will give you referrals to other qualified professionals.

7. Payment is due at the beginning of each session, and no balance will be carried. You are responsible for cooperating with your insurance company to support prompt payment if insurance is being used. If you are paying out-of-pocket, you agree to pay $_______________ for each session.

8. You understand that the Therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing those measures, the Therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

NOTICE REGARDING ADDITIONAL FEES NOT COVERED by INSURANCE

1. Missed appointments and late cancellations (without 24 hours of advance notice): $50 for holding an appointment slot. This is not a fee that your insurance company will cover.

2. Written Reports/Letters/Forms: Pro-rated at my hourly rate. Fees are discussed in session.

3. After Hour Phone Calls (Non-Emergency) or consultative phone calls with other professionals: Pro-rated at my hourly rate. Fees are discussed in session.

4. Any meetings, tele-conferences or Court hearings that I am requested to attend will be charged at my pro-rated hourly rate. Fees are discussed in session.

I agree to all of the above terms.

____
Print Name

____ ____________________________
Signature Date

____ ____________________________
Provider's Signature Date

PATIENT NAME: **DOB:**

Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. If you have questions regarding patient and insurance responsibility for services rendered, please call our business office at 808-258-7271. Please review this payment policy and sign below. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but don't have an up-to-date insurance card, payment in full for each visit is required until we are able verify your plan coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance carrier with any questions you may have regarding your plan coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient registration form before seeing the doctor or register with our business office by phone and sign the patient agreement. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the co-pay or co-insurance portion and in some cases, tax that is not included in fee schedule of your claim is your responsibility, whether or not your insurance company pays your claim.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance may automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, as stated on your monthly statement you may be referred to secondary collections and responsible for up to three (3) times the total amount due. Partial payments will not be accepted unless otherwise negotiated with our business office.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ____________________

Signature of Patient or Responsible Party **Date**

____ ____________________

Print Name **Relation to Patient**

HIPAA Acknowledgment Form

I am required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY:
I have made every effort to obtain written **acknowledgment** of receipt of our Notice of Privacy from this patient but it could not be obtained because:

___The patient refused to sign.
___Due to an emergency situation it was not possible to obtain an acknowledgment.
___We weren't able to communicate with the patient.
___Other *(Please provide specific details)*

____

Provider Signature

____

Date