Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

FINANCIAL POLICY AND OFFICE PROCEDURE

RESPONSIBILITY FOR PAYMENT:

The patient, his or her parent or guardian, or person or agency requesting treatment is fully responsible for all charges incurred. Every effort will be made to verify insurance eligibility and benefit coverage. However, insurance seldom covers the entire fee and the patient is responsible for his/her co-payment at EACH session. Patients without insurance are expected to make payment in full at EACH session. If another person is legally responsible, a signed written statement to that effect, with full and complete insurance and payment information, will be required prior to the initial session.
In cases of financial hardship and with the therapist's approval, a payment plan can be arranged through the office. In some instances, the individual practitioner may make prior arrangements with the patient in regards to a payment plan. A written and signed agreement is necessary if such arrangements are made.

MISSED APPOINTMENT POLICY

Should you find it necessary to cancel your appointment, the cancellation must be made at least 24-hours prior to the scheduled appointment. Failure to cancel or attend appointment will result in your being charged a $50.00 fee for the appointment. This CANNOT be charged to your insurance carrier. Online scheduling provides around-the-clock opportunity to cancel appointments should the need arise. _____ **Initial**

EMERGENCY SERVICES

Patients have 24-hour access to a therapist for EMERGENCY needs.

TELEPHONE CALLS

There will be no charge for brief; infrequent telephone calls between patient and therapist. However, frequent or lengthy telephone calls will be billed as an appointment and is not payable by insurance. During office hours, telephone calls will be returned as time permits. Please leave as much information as possible on the voice mail message.

CONFIDENTIALITY

All information recorded on your chart is confidential and will be held in strictest confidence unless you authorize release of information with a signature, the therapist is ordered by a court to release the information, or the therapist is legally required to report patient information to the proper authority. In addition, the therapist reserves the right to turn over demographic and financial information to a collection agency, credit bureau, or attorney's office should it become necessary. Any debt held in excess of 90 days may be turned over to one or all of these agencies. If we must seek payment through services of a collection agency, the cost of the collection, lawyer fees, court costs, and the cost for processing will be the responsibility of the patient.

Signature of Patient: _____ Date: ____/____/_____

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

PATIENT'S RIGHTS & RESPONSIBILITIES STATEMENT

STATEMENT OF PATIENT'S RIGHTS:

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Patients have the right to know about their treatment choices. This is regardless of cost or coverage by the patient's benefit plan.
- Patients have the right to easily access timely care in a timely fashion.
- Patients have the right to share in developing their plan of care.
- Patients have the right to information in a language they can understand.
- Patients have the right to have a clear explanation of their condition and treatment options,
- Patients have the right to information about Laura Dion Counseling Services PA, its practitioners, services, and role in the treatment process.
- Patients have the right to information about clinical guidelines used in providing and managing their care.
- Patients have the right to ask their provider about their work history and training.
- Patients have the right to give input on the Patient's Rights & Responsibilities policy.
- Patients have the right to know about advocacy and community groups and prevention services.
- Patients have the right to freely file a complaint or appeal and learn how to do so.
- Patients have the right to know of their rights and responsibilities in the treatment process.
- Patients have the right to receive services that will not jeopardize their employment.
- Patients have the right to list certain preferences in a provider.

STATEMENT OF PATIENT'S RESPONSIBILITIES:

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- Patients have the responsibility to ask questions about their care. This is to help them understand their care.
- Patients have the responsibility to follow the treatment plan which is agreed upon by the patient and the provider.
- Patients have the responsibility to follow the agreed upon treatment plan.
- Patients have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as they know they need to cancel visits.
- Patients have the responsibility to let their provider know when the treatment plan isn't working for them.
- Patients have the responsibility to let their provider know about problems with paying their fees.
- Patients have the responsibility to report abuse and fraud.
- Patients have the responsibility to openly report concerns about the quality of care they receive.

My signature below indicates that I have been informed of my rights and responsibilities, and that I understand this information.

_____ _____/_____/_____
Signature of Patient / Parent / Legal Guardian Date

_____ _____/_____/_____
Witness Date

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

CONSENT TO TREATMENT

I consent to evaluation and treatment by Laura Dion, LCSW. I am aware that the practice of Counseling & Psychology is not an exact science, and I acknowledge that no guarantees have been made to me as a result of evaluation and treatment.

I hereby authorize the release of pertinent information from my records to any insurer, compensation carrier, managed health care group, or similar agency that may be providing financial assistance and/or authorization for my treatment. I authorize payment of medical benefits to the provider for services rendered. I also request payment of governmental benefits to the party who accepts assignment.

_____ _____/_____/_____
Signature of Patient / Parent / Legal Guardian Date

_____ _____/_____/_____
Witness Date

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT AND RELEASE OF INFORMATION

Release of Information:

I, the undersigned named patient, do hereby authorize provider Laura Dion, LCSW/Laura Dion Counseling Services PA, to release to any third-party payer (such as an insurance company or governmental agency, example: Blue Cross Blue Shield or Medicare) any medical, psychiatric, or alcohol and drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment.

Therapist Insurance Assignment:

I, the undersigned named patient, hereby authorize payment of medical benefit for services provided by Laura Dion, LCSW/Laura Dion Counseling Services PA

I permit a copy of these authorizations be used in place of the originals. These authorizations will be in effect until revoked by me in writing.

Please remember we file insurance as a courtesy to our patients. If for some reason your insurance fails to pay for your services, you will be responsible for payments.

Printed Name: _____

Signature of Patient or Responsible Party: _____

Date: _____/_____/_____

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

Client Responsibilities:

- Please be on time to get the most out of your scheduled appointment time.

- Please give me 24 hours' notice if you wish to cancel or change your appointment. Late cancels leave a void in the schedule that can be impossible to fill on short notice. It prevents me from offering an appointment to an existing or potential client on a waiting list or in need of an emergency appointment. It also results in a loss of income to me that I am unable to make up. Please be considerate and mindful of this. You will be charged $50 for a late cancellation or for simply not showing up for your appointment. All phone messages are time and date stamped, so please leave a message to cancel your appointment if I am unable to answer the phone at the time of your call. A text message to my cell phone is also an acceptable form of communication for this purpose.

- Remember, reminder calls/texts are a courtesy. You are responsible for your appointment even if you did not get the reminder. Please show up for your appointment.

- Remember you are responsible for paying for services. Although you may have insurance, you are ultimately responsible for paying for services. I do my best to file a claim on your behalf. If the claim is denied, you are responsible for payment.

- Diagnosis. Most insurance and many Employee Assistance Programs require we provide a diagnosis code to describe your condition. Once that information is provided, we accept no liability for the impacts to insurability or employment. _____ (Please initial)

- *I, the client or responsible party, confirm that I understand and agree to these terms*

_____ _____

Client or Responsible Party Signature Printed Name

_____/_____/_____

Date

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐Master Card ☐VISA ☐Discover ☐AMEX
☐Other

Cardholder Name (as shown on card): _____

Card Number **Last four digits only for now**: _____ CSV _____
_____

Expiration Date (MM/YY): _____/_____

Cardholder ZIP Code (from credit card billing address) _____

I _____ , authorize_____to charge my credit card listed above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature_____Date _____/_____/_____

- **No Credit Card information will he kept on a computer.** Information will only be kept in your chart and I, Laura Dion, LCSW, will be the only person to have access to this information. ALL charts are kept in locked files when I am not present in the office.
- **The Missed Appointment /Late Cancellation fee is $50.00.** This CANNOT be charged to your insurance company. If you need to cancel an appointment and give 24-hour notice, you will not be charged this fee. All messages left are time stamped and dated, so if you call me or the office and leave a message, this information will be noted as long as you leave a message to cancel the appointment
- **Remember, reminder calls/texts are a courtesy.** You are responsible for your appointment even if you did not get the reminder.

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

Telemental Health Informed Consent

I understand the following with respect to Telemental Health:

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 risk and consequences associated with Telemental Health, 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 Telemental Health 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 Telemental Health services are not appropriate and a higher level of care is required.

6) I understand that during a Telemental Health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, Laura Dion will attempt to restart the session and or call you. If we are unable to reconnect within ten minutes, please call me at 321-693-8671 to discuss since we may have 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.

8**) I understand that under no circumstance am I to be driving during a Telehealth appointment.**
Initial _____

Laura Dion Counseling Services PA
Laura Dion, LCSW SW8920, Palm Bay, FL 32907 **Phone:** 321.693.8671 **Fax**: 321.701.1982

I _____ , have read the conditions and expectations of Telemental Health and hereby consent to participate in Telemental Health with **Laura Dion, LCSW** as part of my psychotherapy. I understand that Telemental Health 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.

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 on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location 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: _____ Phone_____

Address: _____

I have read the information provided above and, if needed, 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