GPS Guide to Personal Solutions

Intake Forms

Demographic Information

First Name:_____
Middle Initial:_____
Last Name:_____
Date of Birth:_____
Social Security Number :_____
Sex: M F
Marital Status:_____
Address:_____
City:_____
State:_____
Zip Code:_____
Phone Number:_____
Email Address:_____
Referral Source: _____

Insurance Information

Primary Insurance Company:_____
Subscriber ID # (including numbers, if any):_____
Group Number:_____
Secondary Insurance Company:_____
Subscriber ID # (including numbers, if any):_____
Group Number:_____
Insurance Policy Holder Full Name:_____
Insurance Policy Holder Date of Birth:_____
Insurance Policy Holder Address:_____
Insurance Policy Holder Relationship: Self Spouse Child Other
Insurance Policy Holder Social Security Number: _____
Insurance Policy Holder Sex: M F

PATIENT AUTHORIZATION

I authorize the release of any medical and insurance information necessary to process any claim by anyone representing GPS Guide to Personal Solutions.

Patient Signature:_____ Date:_____
Guardian Signature (if minor):_____ Date:_____
Patient Full Name:_____

MANAGED CARE/HMO PATIENTS

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature:_____ Date:_____
Guardian Signature (if minor):_____ Date:_____
Patient Full Name:_____

**Note: All signatures are required.*

NO SHOW OR LATE CANCEL APPOINTMENTS

Commercial Insurances
I have been notified that I will be billed $50 for any appointment I do not show up for, or an appointment that I late cancel for (provide less than 24 hours notice). This will be charged to a credit card that I put on file with my therapist within 48 hours of that missed appt.

Medicaid Insurances
I have been notified that I will be taken off my therapist's schedule and not put back on until I talk to that therapist directly. I may not be put back on the schedule immediately, but at the convenience of my therapist's schedule.

Patient Signature:_____ Date:_____
Guardian Signature (if minor):_____ Date:_____
Patient Full Name:_____

**Note: All signatures are required.*

GPS GUIDE TO PERSONAL SOLUTIONS

Consent to Treatment Agreement

Informed Consent Regarding Limitations on Confidential Communications:

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:
--If necessary to protect my safety or the safety of others.
--If I am clearly dangerous to myself, my therapist may take steps to seek involuntary hospitalization and may also contact members of my family or others.
--If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may:

--Tell any reasonably identified victim
--Notify the police
--Arrange for me to be hospitalized

--If necessary for me to be hospitalized for psychiatric care.
--If a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case.
--In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.
--If the therapist believes a child, a disabled person, or an elderly person in my care is suffering abuse or neglect.
--To provide information regarding my diagnosis, prognosis, and course of treatment or for purposes of utilization review or quality assurance to a third party payer.
--In a legal proceeding where I introduce my mental or emotional condition.
--If I bring an action against the therapist and disclosure is necessary or relevant to a defense.
--If necessary to use a collection agency or other process to collect amounts I owe for services.
--If a court orders access to my records in a sexual assault or other criminal case.

I additionally authorize my therapist to consult professional colleagues and/or supervisors for licensing or certification needs to enhance the clinical services I receive.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Client Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

INITIAL CLIENT QUESTIONNAIRE

Client Name:_____

Date of Birth:_____Ethnicity:_____

Relationship Status (circle one): Married Single Divorced In Partnership

How many times have you been married?_____

List marriages and dates:

How many children do you have?_____

List names and ages:

Who do you presently live with?

What are the major problems in your present household? (Living conditions, relationship problems, financial problems, social problems, etc.)

Are you spiritual or religious?

If so, what religious and spiritual values are important to you?

How did you hear about us?_____

What is the reason for your appointment today? (What are your symptoms, when did they start, how long do they last, how often do they happen?)

CURRENT SYMPTOMS	YES	NO
Have you been down, depressed, or hopeless in the past month?		
Are you bothered by little interest or pleasure in doing things?		
Has your appetite changed (eat more or less)?		
Has your sleep been disturbed (insomnia or over sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid places or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts and/or do repetitive behaviors?		
Have you been through any significantly stressful periods on the past six months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
Do you use prescription meds or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

THERAPY HISTORY

How many psychotherapists/counselors have you seen in the past for this problem and related problems?

Are you presently in psychotherapy/counseling with anyone? (circle one): Yes No

What has been your past experience with psychotherapy/counseling so far?

Any previous psychological testing?_____Do you have reports?_____

What were your symptoms?

Were you diagnosed with a mental illness? (circle one): Yes No When?_____

If yes, what was the diagnosis?

What is your opinion of psychiatric medications?

How many psychiatrists have you seen previously for medication management?_____

What has been your experience with medication(s) so far?_____

What psychiatric medications have you been on in the past?

Have you been hospitalized for psychiatric problems? (circle one): Yes No
If yes, how many times?_____When was the last time?_____

Do you have a violent history? (circle one): Yes No

Have you attempted suicide in the past? (circle one): Yes No

Do you physically hurt yourself? (circle one): Yes No

Do you have thoughts of seriously harming yourself or others now? (circle one): Yes No

Are you an abuser of a victim of abuse? (circle one): Yes No
If yes, please explain:

TRAUMA HISTORY

Have you had significant trauma in your life? (circle one): Yes No
Were you abused or molested as a child? (circle one): Yes No

If yes, please explain the nature of the trauma, when it occurred and the person(s) involved:

FAMILY HISTORY OF PSYCHIATRIC ILLNESS:

Problem/Illness	In Which Family Member
Nervous Breakdown	
Depression	
Bipolar Disorder	
Anxiety/Panic	
Drug Abuse	
Alcohol Abuse	
Suicide with a gun	
Suicide (other)	
Violent crime(s)	
Survivor of abuse	
Abuser or molester	

MEDICAL CONDITIONS AND MEDICAL HISTORY

Circle all problems present now or in the past:

Allergies	Asthma	Chronic cough/bronchitis	Snoring
Chest pain	Heart problems	Palpitations	Mitral valve prolapse
Swelling of feet	High blood pressure	Thrombosis	On blood thinners
Urination problems	Miscarriages	Sexual problems	Sexually transmitted diseases
Abortions	HIV	Weight gain	Weight loss
Diarrhea	Constipation	Liver problems	Heartburn/indigestion
Stroke	Headaches	Ringing in ears	Hearing aids
Vision problems	Thyroid problems	Infections	Tuberculosis
Genetic problems	Diabetes mellitus	High sensitivity to medications	Seizures
Nausea and vomiting	Arthritis/muscle pains	Numbness or tingling	Other problems

Environmental/food allergies? (circle one): Yes No If yes, describe:

Who is your Primary Care Physician?_____

Other doctors seen regularly:_____Psychiatrist:_____

Current list of medications (including psychiatric):

FAMILY HISTORY

Did you have a happy childhood? (circle one): Yes No

Were you raised by your parents? (circle one): Yes No

How was your relationship with your parents growing up?

How is your relationship with your parents now?

How many brothers and sisters do you have?
Are they older/younger?

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SUBSTANCE USE HISTORY

Substance	Age at First Use	Date/Age at Last Use	Duration/Frequency of Use
Alcohol			
Marijuana			
Methamphetamines			
Amphetamines			
Cocaine			
Benzodiazepines			
Barbiturates			
Hallucinogens			
Opiates (prescription)			
Methadone			
Heroin			
PCP (Angel Dust)			
Inhalants			
Prescription Drugs			
Other illicit substances			
Caffeine			
Tobacco			

Have you ever had treatment for substance abuse? (circle one): Yes No
Where and when? Inpatient?

Do you have any medication allergies? (circle one): Yes No If yes, explain:

SOCIAL HISTORY

Do you have significant relationships outside your family? (circle one): Yes No
If yes, with whom, and what kind of relationship?

Who is supportive of you at this time?

Have there been any deaths in your family or support system in the last five years?

Who and when?

DEVELOPMENTAL HISTORY

Describe any developmental milestones or delays (crawling, walking, rolling over, smiling, sitting, standing, etc):

How much difficulty are you having functioning at your work/home/school at this time?

LEGAL HISTORY

Are you facing any legal difficulties at this time? (circle one): Yes No

If yes, please explain:

Have you ever been arrested? (circle one): Yes No

What year(s) and what was/were the charge(s)?

Did you have probation, jail time, or parole? List what one(s) and dates:

EDUCATION/WORK HISTORY

Highest level of education:_____

Recent jobs you have held:

Are you presently having problems functioning at your work/home/school? (circle one): Yes No

If yes, please explain:

STRENGTHS/LIMITATIONS

Please list what you believe to be your strengths and abilities:

Please list anything that is holding you back:

What are some of your needs?

Do you have any specific preferences for your care?

If yes, please describe:

Is there anything you are worried about regarding starting therapy?

If yes, please describe how we can better serve your needs:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purpose of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to: quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purpose PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings: We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel →

→only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crim on the premises.

Specialized Government Functions: We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety: We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research: PHI may only be disclosed after a special approval process or with your authorization.

Fundraising: We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission: We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of a PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 1801 E Saginaw Hwy, Suite 1 Lansing MI 48912:

--**Right of Access to Inspect and Copy**: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to your or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

--**Right to Amend**: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

--**Right to an Accounting of Disclosures**: You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
--**Right to Request Restrictions:** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for the purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
Breach Notification: If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
Right to a Copy of this Notice: You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at (517)667-0061 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202)619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 2013.

Patient/Client Name:_____**DOB**:_____**SSN**:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of [GPS-Guide to Personal Solutions]'s *Notice of Privacy Practice* and that if I have any questions regarding the Notice or my privacy rights, I can contact [Nicole Dingwell, LMSW at (517)667-0061].

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian or Personal Representative* **Date**

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc).

☐ **Patient/Client Refuses to Acknowledge Receipt:**

_____

Signature of Staff Member **Date**

GPS GUIDE TO PERSONAL SOLUTIONS SOCIAL MEDIA POLICY

This document outlines office policies related to use of Social Media. Please read it to understand how GPS representatives and contractors conduct themselves on the internet as mental health professionals and how you can expect your therapist to respond to various interactions that may occur between us on the internet.

If you have any questions about anything within this document, we encourage you to bring them up when you meet with your therapist. As new technology develops and the internet changes, there may be times when GPS needs to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

GPS representatives and contractors do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Linkedin, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of a therapeutic relationship between you and your therapist. If you have questions about this, please bring them up when you meet with your therapist so you can talk more about it.

Following

GPS representatives may publish a blog on their website and/or post therapeutic news on Twitter. We have no expectation that you as a client will want to follow any of our blog or Twitter streams. However, if you use an easily recognizable name on Twitter and we happen to notice that you've followed GPS or your therapist there, we may briefly discuss it and its potential impact on our working relationship.

Social Media Policy

GPS' primary concern is your privacy. If you share this concern, there are more private ways to follow representatives and/or contractors on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to GPS content. You are welcome to use your own discretion in choosing whether to follow anyone. Note that GPS' representatives and/or contractors will not follow you back. GPS only follows other health professionals on Twitter and does not follow current or former clients on blogs or Twitter. The reasoning is that we believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with us, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

Please do not use messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact GPS. These sites are not secure and GPS may not read these messages in a timely fashion. Do not use wall posts, @replies, or other means of engaging with GPS in a public online environment if we already have an established client/therapist relationship. Engaging with GPS or your therapist 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 your therapist of GPS between sessions, the best way to do so is by phone.

Use of Search Engines

It is NOT a regular part of GPS or your therapist's practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with your therapist via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

Business Review Sites

You may find GPS or your therapist psychology 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. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find GPS or your therapists' listing on any of these sites, please know that the listing is NOT a request for a testimonial, rating, or endorsement from you as a client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with GPS or your therapist about your feelings regarding our work, there is a good possibility that we may never see it. If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with GPS or your therapist wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that GPS and your therapist is your therapist or how you feel about the treatment we provided to you, in any forum of your choosing. If you do choose to write something on a business review site, GPS and your therapist 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. If you feel we have done something harmful or unethical and you do not feel comfortable discussing it with us, you can also contact the State of Michigan, which oversees licensing, and they will review the services we have provided.

Location-Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, 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 office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from our office or if you have a passive LBS application enabled on your phone.

Email

We prefer using email only to arrange or modify appointments. Please do not email GPS or your therapist content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with GPS by email, be aware that all emails are retained in the logs of your and GPS/your therapist's 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) of the internet service provider. 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.

Conclusion

Thank you for taking the time to review GPS and your therapist's Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the internet, do bring them to our attention so that we can discuss them.

Client Signature:_____ **Date**:_____

FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing GPS Guide to Personal Solutions. Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, **please ask your provider prior to signing this Agreement and Policy**.

Our service rates and corresponding health insurance billing codes (numbers starting with '90' refer to mental health services) this is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

- **90791** Initial Consultation – Individual (50-60 minutes) -- $225.00
- **90837** Individual Therapy – (60 minutes) -- $150.00
- **90834** Brief Individual Therapy – (45 minutes) -- $130.00
- **90853** Group Therapy – (60 minutes) -- $50.00

ADDITIONAL FEES

- Late cancelations/Missed appointment – (fewer than 24 hours notice prior to the appointment) -- $50.00
- Non-sufficient funds – (bounced check) -- $30.00
- Past-due accounts – (over 30 days) -- $25.00 per month
- Checks returned due to insufficient funds will incur a fee of $45.00

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the ***Outpatient Services Agreement***, which will be given to you along with this Agreement and Policy and our ***Notice of Privacy Practices***. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to GPS Guide to Personal Solutions.

INSURANCE REIMBURSEMENT

GPS accepts and processes insurance payments through a variety of insurance providers and employee assistance plans. If you are using insurance or an employee assistance provider (EAP) to pay for our services, then we will:

1) Expect and accept payment of your copayment amount at the time of service
2) File your claim with the insurance provider
3) Receive payment from your insurance provider

Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.

PLEASE NOTE

GPS files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If your insurance company denies a claim filed on your behalf, then you are responsible to pay GPS for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owners of GPS.

I agree to (1) allow GPS to bill my insurance directly for services provided under the Outpatient Services Agreement; (2) give GPS permission to release any information the insurance company may require in order to process payment; (3) appoint GPS as my authorized representative to act for me in obtaining payment; (4) assign all of my rights to claims and payments by my insurance to GPS; and (5) agree to assist with the claims process as required by GPS for my insurance provider.

I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Patient Name (printed):_____

Patient/Guardian Signature:_____

PRIVATE/SELF PAYMENT FOR SERVICES

I will self-pay for services at GPS. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

If sliding scale Fee : Agreed upon amount per session _____

Patient Name (printed):_____

Patient/Guardian Signature:_____

YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT OF GPS GUIDE TO PERSONAL SOLUTIONS

Welcome to GPS Guide to Personal Solutions.
We hope that we can give you the kind of support and help that you are looking for.

When you receive services from GPS Guide to Personal Solutions **you have the right to:**

- Receive high-quality service
- Be treated with respect and courtesy
- Have your information kept private and confidential except as described in GPS Guide to Personal Solutions *privacy statement* unless the law or a court requires the organization to release it or you give written permission to release information
- To know how much the services will cost you and how much you must pay.
- To take part in developing your service plan or treatment plan and to participate in making changes in these plans.
- To refuse to be involved in research, filming, or taping without your written consent
- To refuse medication, service, or treatment unless law or court order has limited this right, and to be informed of the consequences of refusal and the organization's ability to deliver service,
- Be listened to and have staff work with you to make a plan to address your concerns and needs
- Receive service in offices that are safe, clean and accessible
- Get information and support to help you make decisions to improve your situation
- Be served without discrimination
- Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have
- Request a change of staff member if there is another staff person available who can address your issues and your request is reasonable -- you should know that discriminatory requests will not be considered

This is what we ask from you:

- Treat the staff and others at GPS Guide to Personal Solutions with courtesy and respect
- Let GPS Guide to Personal Solutions know 24 hours before if you cannot come to an appointment.
- To provide clear and accurate information about yourself and to inform you're the agency and/or therapist if your address, income or other circumstances change.
- To ask questions if you do not understand information or instructions about your services and what you are expected to do,
- To pay the fees charged for your services, if there is a fee, and to make arrangements with your insurance company if there is insurance coverage for the services

_____ _____

Client Signature Date