CYPRESS
COUNSELING CENTER, P.C.

NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____

Preferred name: _____ Pronouns (optional): _____

SSN: _____ Gender (for billing purposes): ☐ M ☐ F ☐ Couple

Address: _____ City: _____ State/Zip:_____

Cell: _____ Home: _____ Work: _____

Can CCC call and leave messages? ☐ Y ☐ N Email address: _____

Would you like to receive our quarterly e-newsletter? ☐ Y ☐ N

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Cohabitating

Work Status: ☐ Employed ☐ Unemployed ☐ Full-time Student ☐ Part-time Student

How did you hear about Cypress Counseling Center?_____

Emergency Contact: _____

Relationship to you: _____ Phone: _____

_____ _____
Primary Care Physician Address of Primary Care Physician

_____ _____
Psychiatrist Address of Psychiatrist

Billing information

☐ **INS** ☐ **OOP $** _____

Insured's Name: _____ Date of Birth: _____

Insured's Cell: _____ Home #:_____ Work #:_____

Address: _____ City: _____ State/Zip: _____

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CREDIT CARD AUTHORIZATION FORM

Client Name: _____ Date: _____

The information collected below is used for the purpose of collecting co-payments, deductible payments, co-insurance payments and any late cancellation fees. Please complete the form below and choose the best option for your account.

This form and the information requested is optional and not a condition of receiving services from Cypress Counseling Center. You may opt out by refusing to submit this form or contacting Cypress Counseling Center by phone, mail or e-mail to opt out at any time.

OPT OUT:

- ❏ Do not save my credit card information

OPT IN:

- ❏ Please save my card and make automatic payments for all fees
- ❏ Please save my card and make automatic payments for copays or coinsurance

PLEASE PRINT VERY CLEARLY

Card Type: VISA MC DISC AMEX HSA

Card Number: _____

Exp Date: _____ CVV Code: _____ Zip Code: _____

Phone Number: _____

Cardholder Signature: _____ Date: _____

By signing, you are providing permission for payments to be drafted from your account when indicated above and applied toward the balance of the client listed above.

Client's Name:_____ Date:_____

Person Completing Form:_____

Please check how often these symptoms occurred in the last six months. If you are a parent completing this form for your son/ daughter, please provide his/her symptoms in the *last six months*.

Symptom	Never or rarely	A few times per month	Nearly every day	Symptom	Never or rarely	A few times per month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving home				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heartbeat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Overeating				Drug use			
Bingeing				Blackouts			
Food preoccupation				Stomach problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self/others			
Problems at work/school				Emotional abuse of self/others			
Stealing				Other:			

Medications or other medical issues (allergies, thyroid, diabetes, etc.) _____

_____

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INTAKE INFORMATION

Possible Benefits and Risks of Counseling Services:
Most individuals, couples and families who obtain counseling services benefit from the therapeutic process, which can facilitate improved mood, increased self-esteem and greater ability to make choices that enhance physical, emotional and relational health. However, there are risks. Sometimes clients experience unwanted feelings of unhappiness, anger, guilt, frustration or deep pain when in counseling, which can be unexpected and distressing. In addition, the counseling process sometimes impacts important life decisions. While your therapist will respect your right to make decisions for yourself, important people in your life may not agree with a direction you pursue. You may experience new opportunities and/or unique challenges as a result of engaging in psychotherapy. Don't hesitate to discuss treatment goals with your therapist, especially if you experience unexpected discomfort or are concerned about treatment outcome.

Therapist Availability:
Cypress Counseling Center, P.C. (CCC) is committed to responding to client phone calls promptly. It is reasonable to expect that voicemails you leave for your therapist or emails you send will be responded to within one business day. Discuss schedule availability with your therapist. *In the event of a clinical emergency, call 911, visit your nearest emergency room or contact a community crisis line: For Washtenaw County, University of Michigan Psychiatric Emergency Service (PES): (734) 936-5900 or Washtenaw County Community Support and Treatment Services (CSTS): (734) 544-3050; or in Oakland County, Common Ground: (248) 451-2600*

Payment and Fees:
Payment is expected at the time services are rendered. CCC accepts cash, checks and most credit cards. If payment is not made at the time of service, it is expected that you will settle the bill prior to the next session. Appointments are 45 minutes or 60 minutes in duration. You are responsible for the fees charged. Any change in fees will be discussed with you beforehand. When the client is a minor, the parent/guardian is responsible for the bill. *If you need to cancel or change an appointment, you must notify your therapist at least 24 hours prior to the therapy appointment in order to avoid a late cancellation or missed appointment charge. Please be aware that insurance companies do not cover missed appointments. You will be fully responsible for 50% of the full-fee amount of your session if you do not give the proper 24-hour notification.*

Intake session: $225 | 60-minute session: $200 | 45-minute session: $150 | 30-minute session: $100

Diagnosis & Billing:
You should be aware that most insurance companies require you to authorize your therapist to provide a clinical diagnosis. This information will become part of the insurance company files. All insurance companies claim to keep such information confidential, but once they have it, CCC has no control over its use. You always have the right to pay for services directly and avoid the aforementioned complexities associated with utilizing insurance coverage.

It is in your best interests to share health insurance policy details with CCC so that your coverage can be verified and an accurate insurance claim can be generated. CCC utilizes HIPAA compliant third party benefit coordination services to ensure timely billing. You remain responsible for all charges not paid by insurance. These include deductibles, co-payments, coinsurances, and non-covered, ineligible, and/or unauthorized services. CCC recommends that you verify your coverage prior to or within 24 hours of the first appointment to ensure that counseling services will be covered by insurance.

Other Fees:
Insurance companies cover the cost of psychological testing inconsistently. CCC will attempt to clarify coverage for psychological testing in advance, but in general, you should expect to pay out-of-pocket for these services. There is a $20 charge for all returned checks. Delinquent accounts will require cash, certified check or money order and may be referred for collection and credit reporting as well as interest added to balances over 60 days. You are responsible for all attorneys' fees and court costs incurred by Cypress Counseling Center, P.C. regarding the recovery of unpaid counseling fees.

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PRIVACY NOTICE

Privacy Officer: Dr. Daniel S. Bingham (email: danielbingham@cypresscc.com; phone: (734) 369-3180)

At Cypress Counseling Center, P.C. (CCC), protected health information (PHI) is handled responsibly. Below are the procedures utilized to safeguard PHI, the circumstances under which your personal health information may be disclosed, and your rights as they relate to this information. The rules for confidentiality of mental health records are recorded in the privacy rules of the *Health Insurance Portability and Accountability Act (HIPAA).* It is in your best interests to review these provisions in order to fully understand CCC's procedures and your rights.

We strive to protect your personal health information (PHI).
At Cypress Counseling Center, P.C. (CCC), every effort is made to keep your PHI private. If you have any questions or concerns about your privacy, please address them with your therapist.

Your Rights

You are entitled to copy or review your mental health records.
You have the right to ask to see or get a copy of your mental health record. CCC will provide a copy or a summary of your mental health information, usually within 30 days of your request. A reasonable, cost-based fee may be assessed. You can ask CCC to correct health information about you that you think is incorrect or incomplete. CCC may say "no" to your request, but you will be given a reason why in writing within 60 days.

You can request confidential communications.
You have the right to ask CCC to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You can request limitations on information sharing.
You have the right to ask CCC not to use or share certain information for treatment, payment, or mental health care operations. CCC is not required to agree with your request and might say "no" if it would affect your care. If you pay for counseling services out-of-pocket in full, you can ask CCC not to share that information for the purpose of payment or or our operations with your insurance company. CCC will say "yes" unless a law requires the information to be shared.

You can request a list of those with whom CCC has shared information.
You have the right to ask for a list (accounting) of the times CCC has shared your mental health information for up to six years prior to the date you ask, who it has been shared with, and why. CCC will provide one accounting per year year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can obtain a copy of this privacy notice.
You have the right to ask for a paper copy of this notice at any time. You will be provided one promptly.

You can choose someone to act for you.
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your mental health information. CCC will ensure the person has this authority and can act for you before taking any action.

You can file a complaint if you feel your rights are violated.
You can complain if you feel CCC has violated your rights by contacting the office via the contact information listed on page one. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. CCC will not retaliate against you for filing a complaint.

Your Choices

For certain information, you can tell CCC your choices about what to share.
If you have a clear preference for how your information is shared in the situations described below, let CCC know and your instructions will be followed. Please note: CCC does not use your PHI for marketing purposes and does not sell it.

In these cases, you have both the right and choice to tell CCC to: 1) share information with your family, close friends, or others involved in your care; 2) share information in a disaster relief situation.

If you are unable to tell CCC your preference, for example if unconscious, CCC may share your information if it is in your best interests. CCC may also share your information when needed to lessen a serious and imminent threat to health or safety.

Other Uses and Disclosures

CCC typically uses or shares your mental health information in the following ways:

1) Providing treatment: CCC can use your mental health information and share it with other professionals who are treating you.
Example: A doctor treating you asks another doctor about your overall mental health condition.

2) Running this organization: CCC can use and share your mental health information to run this practice, improve your care, and contact you when necessary. *Example: CCC uses information about you to manage your treatment and services.*

3) Billing your services: CCC can use and share your information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

CCC is also allowed or required to share your information in the following ways:

CCC may use your information in ways that contribute to the public good, such as public health and research. Many conditions in the law have to be met before your information can be shared for these purposes.
For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

1) Help with public health and safety issues: CCC can share health information about your for certain situations such as preventing disease, help with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

2) Comply with the law: CCC will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that CCC is complying with federal privacy law.

3) Address workers' compensation, law enforcement, and other governmental requests: CCC can use or share mental health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

4) Respond to lawsuits and legal actions: CCC can share mental health information about you in response to a court or administrative order, or in response to a subpoena.

The following individuals can access a mental health record without written authorization.
1) An adult recipient of services; 2) the parent or guardian of a child who is under 14 years of age; 3) a recipient who is 14 years of age or older; 4) the parent or guardian of a recipient who is at least 14, but under 18, if the recipient does not object or if the therapist does not find compelling reason for denying access; 5) a legal guardian of a recipient who is 18 or older. CCC provides assistance in understanding the mental health record.

Our Responsibilities
CCC is required by law to maintain the privacy and security of your PHI. You will be informed promptly if a breach occurs that may have compromised the privacy or security of your information. CCC is obligated to follow the duties and privacy practices described in this notice and provide you a copy of it. CCC will not use or share your information other than as described here unless you provide consent in writing. Once you have provided consent, you may change your mind at any time. Let CCC know in writing if you change your mind.
For more information see: www. hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
CCC reserves the right to change the terms of its Privacy Policy and to make the new Privacy provisions effective for all PHI that it maintains. The new policy will be available upon request, in the office, and on the CCC web site. Rev. 05/19

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CONSENT TO TREATMENT

I consent to engage in counseling services at Cypress Counseling Center, P.C. (CCC). I have received and read the **Intake Information** form explaining the risks and benefits of treatment, the fees for services, and other policies, and agree to the terms specified therein.

I have received and read the **Privacy Notice** as required by the Health Insurance Portability and Accountability Act (HIPAA). I will ask for explanation and clarification of any part of the Intake Information or Privacy Notice that I do not understand.

I understand that **I am responsible for my bill**. While CCC will assist me in pursuing insurance or EAP reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 60 days may result in turning my account over to a collection agency. I understand that CCC may elect to end treatment if timely payment for services is not made.

I understand that **I will be charged 50% of the full-fee amount of my session** for failing to show or for failing to give **at least 24 hours notice** when canceling an appointment. I understand that insurance companies and EAPs cannot be billed for this fee and therefore charges for missed or late cancel appointments will be my responsibility.

If I am electing to use my insurance or EAP benefits, I authorize release of necessary information to my insurance company or EAP so that CCC, acting as my agent, may pursue payment for the services provided to me. I authorize insurance or EAP payments to be sent directly to CCC.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Other Family Member Date

_____

Other Family Member Date

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CONSENT TO CONFER WITH PRIMARY CARE PHYSICIAN

Cypress Counseling Center, P.C. (CCC) believes it is desirable for your therapist to confer and work together with your primary care physician (PCP) on your care. Please indicate your willingness to allow your therapist to communicate with your PCP by checking the appropriate box below and providing the requested information.

☐ **I agree** for you to notify my PCP that I am seeking or receiving mental health services. In addition to this form, I am signing the attached Consent for Release of Information permitting CCC to communicate with my physician.

☐ **I waive** notification to my PCP that I am seeking or receiving mental health services and I direct my therapist to refrain from notifying him or her.

☐ I do not have a PCP and do not wish to meet with one. **I therefore waive notification** to my PCP that I am seeking or receiving mental health services.

_____

Primary Care Physician

_____

Physician's Address

_____

Client Signature Date

_____

Parent or Guardian Signature Date

_____

Therapist's Signature & Credentials Date

Notification sent to physician on _____

(Date)