

# Counseling Services Application

**Babbling Brook Counseling Services, PLLC**

Fax to 540.215.7226 or email: Brooke.Jernigan@LCSW.live

<b>Personal Information</b>					<input type="checkbox"/> <b>Check if Child Under 18</b>	<input type="checkbox"/> <b>Check if Student</b>
First Name			Middle Initial	Last Name		Today's Date
Mailing Street Address			City	State	Zip	Birth Date
Preferred Phone #		Secondary Phone:		<input type="checkbox"/> Business <input type="checkbox"/> Home <input type="checkbox"/> Cell		e-Mail Address
Gender on Ins. card	Work: <input type="checkbox"/> Full <input type="checkbox"/> Part-time	Preferred Pronoun:		Employer Name		SSN (for insurance purposes)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Profession:					
List Present or Previous Health Problems				List Any Past or Present Medications		
				Previous mental health counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Marital Status: S M W SEP D</b>					<input type="checkbox"/> <b>Spouse Information</b>	<input type="checkbox"/> <b>Parent Information if Child</b>
First Name			Middle Initial	Last Name		Marriage Date
Mailing Street Address			<input type="checkbox"/> (Check is Same as Above)	City	State	Zip
Preferred Phone #		Secondary Phone:		<input type="checkbox"/> Business <input type="checkbox"/> Home <input type="checkbox"/> Cell		e-Mail Address
Gender	Work: <input type="checkbox"/> Full <input type="checkbox"/> Part-time	Employer Name		SSN (for insurance purposes)		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Profession:					
List Present or Previous Health Problems				List Any Past or Present Medications		
				Previous mental health counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Children Information (List All Children)					
Name	Birth Date	Lives With You?	Name	Birth Date	Lives With You?

Other Information (PLEASE CHECK ALL THAT APPLY)	
<input type="checkbox"/> History of grief/loss <input type="checkbox"/> Substance abuse in family <input type="checkbox"/> Legal involvement <input type="checkbox"/> Problems at work/school <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Mood symptoms <input type="checkbox"/> Isolation issues or fears/phobias <input type="checkbox"/> Traumatic events <input type="checkbox"/> Anxiety symptoms or compulsive behavior <input type="checkbox"/> Concentration or attention problems <input type="checkbox"/> Financial stress <input type="checkbox"/> Behavioral problems/aggression <input type="checkbox"/> Current/past substance abuse <input type="checkbox"/> Social skill deficits <input type="checkbox"/> Marital conflict <input type="checkbox"/> Severe mood swings or irritability <input type="checkbox"/> Impulsive behavior <input type="checkbox"/> Other: _____	
What do you hope to change or accomplish by seeking help at this time? (Use the back of form if more room is needed).	List any agencies or other professionals who have provided you counseling services in the past and any previous mental health diagnoses, if applicable.
Signature	Signature

**Mental Health INSURANCE INFORMATION**

*(If you are self-pay, you may skip this page)*

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**Please Complete All Information That is Applicable**

Do You Want Babbling Brook Counseling Serv. to Make Claims to Your Primary Insurance?  Yes  No

<b>Primary Health Insurance</b>					Member #	Subscriber/Insured Name	
Mental Health Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Visits Authorized	Begin Date	End Date	Authorization #	Representative Name		Date of Call

<b>Secondary Health Insurance</b> <small>BBCS typically does not file secondary insurance, you must still disclose ins.</small>					Member #	Subscriber/Insured Name	
Mental Health Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of Visits Authorized	Begin Date	End Date	Authorization #	Representative Name		Date of Call

<b>Other Health Insurance</b> (attach details)	<b>Address</b>	<b>Phone</b>
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<b>Other Third Party Payer</b> (attach details)	<b>Address</b>	<b>Phone</b>
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<b>Referred By</b> (name of physician, friend, pastor, bishop, etc.)	Is client's condition related to employment, auto accident, or other accident or event?
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**Medicare / Medicaid Clients** **DO NOT ACCEPT Aetna Medicaid or United Healthcare Medicaid**

<b>Insurance Company</b>	Anthem BC/BS Medicaid _____ Humana Medicare _____	<b>Health Insurance #</b> _____
	Sentara Medicaid _____ Anthen BC/BS Medicare _____ Aetna Medicare _____	<b>Medicaid #</b> _____

# of Visits Possible	# of Visits Authorized	Begin Date	End Date	Authorization #	Representative Name	Date of Call
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Was insurance called and verified in regards to number of allowed visits or if preauthorization is required? \_\_\_\_ YES / \_\_\_\_ NO

<b>EAP (Employment Assistance Program)</b>	<b>Phone</b>	<b>Employer</b>
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## Counseling Description of Services with Babbling Brook Counseling Services, PLLC

**Goals and Outcomes:** Thank you for choosing Babbling Brook Counseling Services for your care and I look forward to helping you meet your goals. Your goals are more likely to be met when you understand the nature and limitations of counseling. Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing, feelings, thoughts, and /or behaviors. You determine the nature and amount of change you wish to make.

**Benefits and Risks** Most people experience improvement or resolution to the concerns that brought them to counseling, but of course, there are no guarantees: and there are some risks. For example, counseling could open up new levels of awareness that may cause discomfort.

**Length of Therapy** Many counseling issues can be resolved in 12 or fewer sessions, however some issues require more extensive care. Insurance companies require medical necessity for counseling so your progress will be evaluated throughout treatment and appropriate referrals for continued care after service termination may be discussed. If two months have passed since your last appointment or contact with me your case will be closed. If you choose to return to services at any time in the future your case can easily be reopened and you will be asked to update your information

**Confidentiality:** I understand that the information you share in counseling is personal. I will not release confidential information without a written release of information form unless such release is authorized or required by law. Your information is protected but there are certain situations which I am required by law to disclose the information. For example, I am a mandatory reporter of child abuse/ neglect and intent to harm yourself or others. By signing this description of Services you acknowledge receipt of **Babbling Brook Counseling Notice of Privacy Practices**. This document describes your rights and my obligation regarding the use of your private health information. Please be aware that insurance companies require a mental health diagnosis and other identifying information, including but not limited to, date of birth social security number and address.

**Payment for Services:** The fee for the initial 60 minute assessment is billed to insurance for \$200. Subsequent 45 minute sessions are billed at \$145.00 & 60 minute sessions at \$185. Please call your insurance company in advance (benefits number or web site listed on your health insurance card) for information about your mental health coverage including if visits require pre- authorization, if there are a limit to the number of visits and what your copay (your part of the fee) will be. Please be prepared to pay your copay at each visit. I accept cash, credit, or checks for payment. If you do not have a mental health diagnosis or you are participating in life coaching sessions insurance will not cover services and you may choose to pay a discounted self pay fee. Consultation outside of the office is billed at \$145.00 per hour including travel time and is not covered by insurance. Returned check fee is \$40.

**Appointment Cancellation:** On occasion a situation may arise which prevents you from keeping a scheduled counseling appointment and I understand. As a courtesy please notify me at least 24 hours in advance of your appointment if you cannot keep it so I can offer it to another client. Except in emergency situations, you may be personally charged a **\$145 cancellation/ no show fee** to offset the lost appointment time. Insurance companies will not cover a no show fee.

**Emergency Phone Contact:** Your phone calls are received 24 hours a day by a confidential voicemail system. Please leave a message and I will make every effort to return your calls as soon as possible. I do not charge for brief 5 min phone calls but do charge for ongoing or lengthy phone communication. Please leave a message marked urgent if you are in crisis and call 911 if you are in imminent danger of harming yourself or others.

I have read the above information, and understand that I am encouraged to ask questions and give input regarding the counseling process at any time. If there is anything in this form that I do not understand it is my responsibility to seek clarification.

Answer Yes or No

Do you want Babbling Brook Counseling to file claims to your primary insurance company \_\_\_\_\_ (Yes/No/ EAP only)

Babbling Brook Counseling Services, PLLC does not bill secondary insurances.

It is my understanding that my Mental Health copay or fee for each session is \$ \_\_\_\_\_

It is my understanding that my insurance deductible for mental health is \$ \_\_\_\_\_, remaining balance is \$ \_\_\_\_\_.

Answer Yes or No

I testify that I only have one insurance plan \_\_\_\_\_. (Yes/No). I have Medicaid \_\_\_\_ (Yes/No). I have Medicare \_\_\_\_ (Yes/No).

I have Commercial Insurance \_\_\_\_\_ (Yes/No).

Signature (s): \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Release/Exchange of Health Information (OPTIONAL)**

**Babbling Brook Counseling Services, PLLC  
302 Washington Ave, SW  
Roanoke, VA 24121**

I \_\_\_\_\_, hereby authorize Babbling Brook Counseling Services to:

*Please initial below all that apply:*

\_\_\_\_\_ Exchange information with \_\_\_\_\_ Release information to \_\_\_\_\_ Obtain information from  
Name of person/agency and address and phone number: \_\_\_\_\_

For the purpose of **coordination of care and treatment** and (add any other purposes)

Information to be released /exchanged (please initial all that you authorize):

- \_\_\_\_\_ Summary of treatment / verification of mental health treatment
- \_\_\_\_\_ Mental health treatment plans and/or progress notes
- \_\_\_\_\_ Information concerning past or present substance abuse
- \_\_\_\_\_ Information for billing

*I understand that:*

- I may inspect or copy the protected health information to be disclosed.
- Information used or disclosed pursuant to this authorization may be subject to secondary disclosure by the recipient, for which Babbling Brook Counseling Services will not be held responsible.
- I may refuse to sign this authorization and that you will not condition treatment upon that decision.
- That my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent except that release which is provided for or required within Federal and State laws and regulations
- I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it (ie. Records released after consent given and prior to consent being revoked).
- This consent will expire one year from the date signed or with written cancellation or on \_\_\_\_\_ (Expiration date or event such as termination of treatment.)

\_\_\_\_\_  
**Client's Name (PLEASE PRINT)**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Date of Birth

\_\_\_\_\_  
Client's Social Security Number

\_\_\_\_\_  
Client's and/or Legal Guardian's Signature

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
**Spouse (PLEASE PRINT)**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Date of Birth

\_\_\_\_\_  
Spouse Social Security Number

**\*CANCELLATION OF CONSENT**

The person who signed this authorization may cancel this consent at any time. A written notice may also serve as a notice of cancellation. Cancellation of consent will not apply if received after information has been released. I cancel this consent on

(Date) \_\_\_\_\_ (Signature) \_\_\_\_\_

# Babbling Brook Counseling Services, PLLC

## NOTICE OF PRIVACY PRACTICES

(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a counseling session.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of March 23, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a complaint:

The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll-free: 1-877-696-6775

Client signature: \_\_\_\_\_

Date: \_\_\_\_\_

Spouse or significant other signature: \_\_\_\_\_

Date: \_\_\_\_\_