The
Growth Center

Date: ___/___/___ Patient Name: ______________________________ [M / F] DOB:___/___/___
SS#: ____-___-____ Home Address: ____________________________City____________Zip________
Home Phone #: ______________Cell #:_________________ Alternate Phone #________________
Employer/School: ________________________ Phone #: _______________

Marital Status (circle one): Child Single Partnered Divorced Widowed Married: ___/___/___
Legal Status (circle one): Joint Custody Sole Custody Legal Guardianship Not Applicable
Relationship to Patient: Parent / Spouse / Partner / Legal Guardian / Self / Other:____________

Name - Parent/Mother : _________________________________ Phone #: _____________________

Name - Parent/Father : _________________________________ Phone #:_______________________

Names & Ages of Biological/Step Children:
____

I was **referred** by: ___________________(circle) Doctor, Minister, Family, Friend, Former Client, Self

Family Physician: ____Phone #:_____________________

Address: ____ Last Medical Exam:________________

List any significant medical or physical information your provider should know. (eg. illness, weight gain or loss, changes in diet or sleep patterns, drug use, alcohol use, etc.)
____
____
____

List any **medications** that you are presently taking:____
____

Previous Treatment/Counseling:(If yes, with whom)____

Emergency Contact: ________________________________ Phone #: ____________________________

Brief description of **reasons for seeking services**:____
____

Name of Health Insurance. Co: ____

Policy Holder:____ Policy Holder's DOB: ___/___/___

Policy Holder's SS#_____-____-_____ Policy Holder's Employer: _______________________________

I understand that **Indiana law** requires that a parent, custodial parent or legal guardian must consent to treatment for anyone under age 18. My signature below indicates I have this status and give this consent for my child if they are involved in this treatment. **I hereby consent for the above named patient to receive mental health treatment at the Growth Center.**

Your Signature: ______________________________________ Date: __________________

Financial Contract

With ____, Client

Our standard fee is **$125** per session for individual, couple and family psychotherapy. The intake fee is **$175**. Our fee for group psychotherapy is $**50** per session. The fee for psychiatric services is **$250** for a psychiatric evaluation and **$95** for medication management.

Type of Therapy: Individual___ Couple___ Family___ Group___ Psychiatric Services___

Based upon your agreement with the provider, your fee is $_______________.

Your fee for service is payable before each session. Payment can be made using cash, personal check, Visa, Master Card or Discover. Upon request you can receive an invoice as a receipt for your session.

For clients filing insurance a co-pay is due before each session. A copy of your insurance card is required along with all necessary preauthorization numbers required by your insurance carrier. You are expected to pay the full fee if insurance authorizations are not completed in advance prior to your services. **You are responsible to inform the office of any change in your insurance coverage. You are also responsible for any fees for services that are not covered by your insurance.** The Growth Center will file the insurance claims and receive payments by assignment. Your signature below gives permission for assignment of benefits to come to The Growth Center for insurance payments made for our clinical services. You hereby authorize the provider to release all information necessary to secure the payment of benefits to any billing agent for the provider, any insurance company and any referring physician. Your signature also acknowledges you have read and understand the HIPAA notice of privacy practices and patient's rights and responsibilities document.

Insurance Company___________________________ **Policy #**_____________________________________

Subscriber___________________________________ **Employer** ___________________________________

Your signature on this form will give the Growth Center permission to communicate with your referring professional, other healthcare professionals you see for services and your insurance carrier to verify your personal information. If your account becomes delinquent, it may be processed through an external collection agency. All returned checks will be subject to a $**25** service charge. Fees may change without advance notice.

Professional time outside the clinical services listed above will be billed at $**400** per hour door to door including wait and travel time. Court appearances require a 3 hour minimum to be paid 3 business days prior to the court date. Courts outside Floyd county incur extra mileage charges. DISABILITY or CUSTODY evaluations are NOT provided at the Growth Center. Photocopy charges will be billed at the rate for medical records established by Indiana law. For this reason fees are subject to change.

In the event that you need to delay your payment for a session please make arrangements in advance with the office manager. A 24 hour notice is required to cancel a session. **There is a $50 fee for late cancellations and missed appointments.** These charges must be paid in full before further services can be provided. The Growth Center does not accept Medicaid, Medicare or ACA Exchange plans.

I have read and understand the terms of this financial contract and agree to the terms herein.

Signed____ (Person responsible for the fee)

Signed____(Person responsible for the fee)

Signed____(Growth Center representative)

The

Growth Center

For

Counseling and Wellness

Notice of **The Growth Center** Privacy Practices

(HIPAA) Effective April 14th, 2003 (2014 revision)

This notice tells you how we make use of your health information at our center. Further, the notice tells you how we might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material that you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have legal responsibility under the laws of the United States and the state of Indiana to keep your health information private. It is our responsibility to give you this notice about our privacy practices and for us to follow the practices in the notice.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or what we created here at The Growth Center (hereafter TGC). These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy at no charge to you. If you request a copy of this notice any time in the future, we will give you a copy at no charge to you.

Here are some examples of how we may use and disclose information about your health information:

- To your physician or other healthcare provider/s treating you
- To anyone on our staff involved in your treatment program
- To any person required by federal, state, or local laws to have lawful access to your treatment program
- To receive payment from a third party payer for services we provided for you
- To our own staff or governmental agencies in connection with TGC operations:
  - Examples of this include, but are not limited to the following: any evaluation of the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, certification or complaint activities
- To anyone you give us written authorization to receive your health information, for any reason you want. You may revoke this authorization in writing at anytime. When you revoke an authorization it will only affect your health information from that point on.
- To a family member or a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you the opportunity to object. If you object, are not present, or are incapable of responding; we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In doing so, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.

By the Statutes of the State of Indiana, your provider will not deliver reports or discuss what you talk over in treatment with persons not indicated in the examples above, except in the following cases: your written consent to release the information, compelling circumstances indicate with a reasonable certainty, a threat to any person's health or safety, pursuant to the order of a court of competent jurisdiction.

Signature: ______________________________ Date: ______________

Statement of Agreement

Please read and sign the following Statement of Agreement. If you have any questions or concerns about any part of this agreement you may discuss them with your provider.

1. The Growth Center Mental Health service providers operate within the standards of professional ethics of their certifying and licensing Associations.

2. Communication between you and your provider is noted and kept in a file. These records are part of your medical record. The confidentiality of the mental health care relationship will be carefully maintained unless you request and authorize your provider to release information to a third party. The law places limits on confidentiality In rare cases of actual or potential harm to yourself or other persons. Examples include, child abuse, threat of harm to yourself or others, etc.

3. On rare occasions you may encounter someone in the waiting area of The Growth Center that you are acquainted with. You are responsible to keep this person's presence confidential.

4. For counseling, medication or therapeutic purposes you may elect to see more than one provider at Growth Center . If you choose to do so, your signature authorizes your providers to discuss your concerns with each other to coordinate and enhance your care.

5. All appointments broken or canceled without a 24 hour notice will be charged to you at our missed appointment fee. If necessary, you may leave a cancellation notice on the Growth Center voice mail.

6. Individual, couple and family counseling sessions are 45 minutes Psychiatric evaluations are 45 minutes and medication managements sessions are 10-15 minutes. If your treatment needs warrant extending your session beyond the scheduled, alotted appointment time you will be responsible for any fees due for a longer appointment.

7. During office hours your call will be answered by Growth Center staff or leave a message and your call will be returned as soon as possible. After hours in the event of an emergency you can call Wellstone Regional Hospital in Jeffersonville at 1-877-999-9355 or (812) 284-8000. This is our after hours service provider.

8. If you are bringing your child for services at The Growth Center and you are a divorced parent with joint custody, then you are fully responsible for informing the other custodial parent about this mental health treatment. This is not the responsibility of The Growth Center or your service provider.

Signature____ Date_________________

The
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Office Policies

CANCELLATIONS

If an appointment is cancelled or missed without a **24-hour notice**, the patient will be charged a **$50 Fee**. Payment of this fee is due before any subsequent medication requests may be considered or before the next appointment with the provider. *I have read and understood the above _______ (initial here).

APPOINTMENTS

Appointments can be rescheduled with your counselor while you are in the office or you may call to reschedule. A message to cancel an appointment can also be left at any time. Patients are expected to arrive within 10 minutes of the scheduled apt. time or the appointment may need to be rescheduled. Providers make every effort to stay on schedule but delays can be needed due to quality of care. Your flexibility is expected.

EMERGENCIES

The Growth Center is **not** a 24-hour emergency service. **In case of an emergency please call Wellstone Regional Hospital at 1-877-999-9355 or 284-8000.** Or, you may go to the emergency room of your local hospital. When our office is closed you may leave a voicemail on our automated service and the message will be checked when office hours resume.

PAYMENT OF FEES

Fees are to be paid at the time of services. You are expected to make your payment prior to your session. Any exception to this must be made **in advance** with the director prior to your session.

WAITING ROOM

Young children **may not** be left unattended in the waiting room. We cannot be responsible for their care. When children are in counseling sessions, parents are expected to be in the waiting room in case they are needed by the counselor. If a parent cannot wait during the session they are expected to make the treatment provider aware of this prior to the session.

PSYCHIATRIC SERVICES

Patients are fully responsible for following-up with medication management appointments as recommended by our medical staff. Patients who miss their appointment must wait until they attend a medication management appointment to have additional medication prescribed. Patients who have not followed through with the required appointment for medication management for 6 months **will no longer be considered active patients.** After 6 months, patients who wish to have further treatment will be considered new patients and be re-evaluated. **Patients are required to send a payment or co-pay with their child for all appointments.**

FORMS REQUESTS

All forms must be brought into the office to be reviewed for approval by your provider outside of an appointment. If approved, a TGC representative will call to schedule an appointment with your provider to complete the requested forms. This may result in the necessity to reschedule your regularly scheduled med management appointment so that it coincides with the form appointment.

LETTERS AND RECORDS REQUESTS

All letters and records requests must be submitted to the office 3 days in advance. There is a $25 charge for each request. Additional fees will apply for rushed or extensive requests.

MEDICATION NEEDS AND REFILLS: CALL (812) 941-9200

Refills and samples (when available) will be given at med management sessions. If refills are needed between sessions **the patient is responsible for contacting TGC** as follows:

1. *All Medication-refill requests:* must be called in to our med coordinator after 2:30, or your pharmacist any time, **one week in advance.** When leaving a message be sure to leave your name, the medication you are requesting, and your pharmacy phone number. Controlled substances must be written scripts.
2. *3 Month Rule:* **No refills or samples** can be given without a med management appointment if it has been more than 3 months since your last appointment. **No medication will be given until the next appointment is kept.**
3. *Medication Questions or Concerns:* May be called in to our med-coordinator from 9-4 who will contact your provider. We do not provide emergent services.

I have read, understood and agree to abide by these policies as a client at The Growth Center.

Signed ____ **Date** _____________________ rev. 7/2015

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS: You have the right to:

* Voice your opinion about the care provided and to recommend changes in policies and services by contacting your health care provider.
* Be provided with information about the organization and its services.
* Participate in decisions about your health care and treatment plan.
* Be treated with respect and dignity.
* Receive from your health care provider complete information about your diagnosis and proposed procedure or treatment alternative, including non-treatment, in order to give informed consent.
* Refuse any procedure or treatment if you so desire and to extent permitted by law, be told what effect this may have on your health.
* Receive full consideration of privacy or confidentiality with regard to all information and records about your care.
* Know the cost (co-payment, deductible, co-insurance) of care and treatment and receive an explanation of your financial obligation when required.
* Have 24-hour access to your health care provider or covering physician.
* Be informed of the names, specialties and qualifications of the physicians.
* Be informed of the grievance procedure.
* Receive prompt and reasonable responses to questions and requests.

PATIENT RESPONSIBILITIES:

* Know the benefits and exclusions of your coverage.
* Provide your health care provider with complete and accurate health information.
* Follow the treatment plan agreed upon by you and your health care provider.
* Contact your health care provider for any care needed after-hours or for any questions and assistance.
* Treat your health care provider and staff with respect and dignity.
* Know how to access health care services in routine, urgent and emergency situations.
* Attend prior arranged appointments and contact your health care provider at the soonest opportunity when you learn that you can not meet an appointment.

_____________________________________ _______________________________ ___________

Responsible Party Signature | Relationship to Patient | Date

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4925 Charlestown Road New Albany, IN 47150