

APPLICATION FOR SERVICES



DATE: _____ **CLIENT ID #** _____

NAME: _____ **BIRTHDATE:** _____

SS#: _____ **PH (C):** _____ **PH (H):** _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **EMAIL:** _____

MARITAL STATUS: Widowed Single Married Divorced Separated

SEX: Female Male Transgender **Gender Identity:** Transgender Non-Binary

Race: White African-American Asian American Indian Pacific Islander

Hispanic or Latino Alaskan Native Other **Veteran:** Yes NO

HOW DID YOUR HEAR ABOUT US? (Referral Source)

Name/Clinic: _____ **Ph #:** _____

EMERGENCY CONTACT

Name: _____ **Ph #:** _____ **Relationship:** _____

Address: _____ **City:** _____

State: _____ **ZIP:** _____ **Email:** _____

INSURANCE INFORMATION

Insurance Name: _____ **Specified Plan:** _____

Policy or ID#: _____ **Group #:** _____ **Ph #:** _____

Policy Holder Info: Name: _____ **DOB:** _____ **Ph #:** _____

INDIVIDUALS INVOLVED IN MY CARE

Highland Springs Specialty Clinic complies with the Health Information Portability and Privacy Act (HIPAA). These regulations allow us to share your Protected Health Information (PHI) with others that you consider part of your care team. This can include other healthcare providers. To release information to family, friends or any other party a signed Release of Information form is required. For additional space, request an addendum form.

Name: _____ **Relationship:** _____ **Ph #:** _____

Address: _____

*You can list more on the back of the page if needed.

PRIMARY CARE PHYSICIAN

NO PRIMARY CARE PHYSICIAN (INITIAL IF YOU **DO NOT** HAVE A PCP.)

Name: _____ **Clinic:** _____ **Specialty:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Ph #:** _____

ACKNOWLEDGEMENTS AND CONSENT



Applicant Name _____ Client Id # _____

Initial each item received:

_____ **PRIVACY NOTICE**

The Privacy Notice tells you how we may share your protected health information (PHI). It lets you know when your permission is required to share protected health information (PHI) with others. Please read the Privacy Notice carefully.

_____ **RIGHTS AND RESPONSIBILITIES**

This describes your rights and responsibilities as a client.

EMERGENCY MEDICAL CARE

I consent to receive first aid and emergency treatment. This would be if I have an accident, injury, illness or other medical emergency. I understand this applies only during treatment at Highland Springs Specialty Clinic.

CONSENT

I certify the above information is accurate and complete. I consent to treatment and testing / assessment at Highland Springs Specialty Clinic and with Telehealth. I understand testing includes, but is not limited to: intellectual, cognitive, developmental and functional testing.

I hereby consent to have Highland Springs Specialty Clinic staff to communicate with me, where appropriate via e-mail and text messages regarding the following aspects of my medical care and treatment (*prescriptions, appointments and billing*). I understand that e-mail and text messages are not a confidential method of communication. I further understand that there is a risk with these means of communication between my treatment team, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment that may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail and/or text communications between my physician, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment may be printed out and made a part of my medical record. _____ *Client Initials*

I understand that in an urgent or emergency situation I should call my provider or go to the Emergency Room and not rely on email.

Client or Parent/Guardian Signature

Date

Client or Parent/Guardian Printed Name

Relationship to Client

Staff Signature

Date

**CLIENT FEE AGREEMENT-
CANCELLATION & PAYMENT POLICIES**



Client ID # _____

Name: _____ DOB: _____ Effective Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ SS #: _____ Insurance: _____

BY SIGNING THIS FORM, I AGREE TO THE FOLLOWING:

- I understand that payment/co-pays are due at the time of service for ALL services.
- I understand that my insurance may not cover all services provided, and that I will be expected to pay for uncovered services at the self-pay rates.
- I understand that Highland Springs Specialty Clinic does not bill Medicaid for services rendered and that I am opting out of any Medicaid coverage, including retroactive Medicaid coverage for any services rendered.
- I understand that Highland Springs Specialty Clinic will bill my health insurance or other payer the full cost of services for all covered treatment and services I receive.
- I understand that I must notify Highland Springs Specialty Clinic of any changes to my insurance or coverage and that by failing to do so I will be liable for the self-pay rates for all services provided.
- I understand that if my insurance is terminated and I am not covered on the date of service that I will be charged the self-pay rates for all services I have received after the insurance termination date.
- I agree to send Highland Springs Specialty Clinic all payments from insurance or third-party payers that I have received directly for services I have received from Highland Springs Specialty Clinic and that failure to do so will result in me being liable for such payments.
- I understand that Highland Springs Specialty Clinic does NOT accept checks
- I understand that Highland Springs Specialty Clinic has the right to refuse to provide additional services and send my account to a collection agency for resolution after 90 days of non-payment for services.
- If my account is sent to a collections agency, I understand that I am liable for all costs incurred by Highland Springs Specialty Clinic including court filings, constable fees, attorney fees, and interest accumulation at the legal rate on the unpaid balance until the balance is **paid in full**.
- I understand that there are fees associated with missed appointments that are not cancelled/rescheduled with 24 hours' notice. **The fee is \$50.00 per missed appointment.**

Authorizations

- I authorize my insurance company or third-party payer to make payments, otherwise payable to me, directly to Highland Springs Specialty Clinic. In the event that the benefits paid exceed the total cost of services Highland Springs Specialty Clinic will be responsible for issuing a refund.
- I authorize Highland Springs Specialty Clinic to pre-authorize services with my insurance company and to appeal, on my behalf, any decision made by the insurance company regarding payment.
- I authorize Highland Springs Specialty Clinic to disclose personal health information to my insurance company or any other entity responsible for paying for my treatment in order to obtain reimbursement.

This fee agreement covers all services provided by Highland Springs Specialty Clinic including mental health and substance abuse treatment.

Client/Parent Signature

Date

Client/Parent Printed Name

Relationship to Client

Witness Signature

Date



HIGHLAND SPRINGS SPECIALTY CLINIC Cost of Services ADDENDUM

This addendum discloses/clarifies the cost of service selected for specific treatment.

Cost of service is due at the time of each service.

Services	Self Pay Rate
Assessment/Medication Evaluation	\$134.98 (per hour) *Most evaluations are 90 minutes = \$202.46
Individual Psychotherapy	\$110.72 (per hour)
Family Psychotherapy	\$110.58 (per hour)
Group Psychotherapy	\$40.00 (per hour)
Medication Management (APRN)	\$94.79 (per session)
Nurse Services (RN)	\$41.44 (per session)
TMS- Treatment	\$2,000.00
TMS- Maintenance Treatment	\$100.00 (per session)
Urine Drug Screen	\$40.00
Paperwork Appointment	\$65.00
No-Show appointment charge	\$50.00
Other:	\$
Other:	\$
Other:	\$

By signing this form, I understand that, in the event that my insurance company does not cover the services rendered, I will be charged the above self-pay rates for these services.

Client/Guardian/Signature: _____ Date: _____

Printed Client Name: _____ DOB: _____

Staff Signature: _____ Date: _____

Client ID: _____ Unit #: _____