Client Information

Primary Client Information:

Name: _____ Date of Birth: _____

Social Security Number: ____-____-_____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Leave Message: (Y/N): _____

Cell Phone: _____ Leave Message: (Y/N): _____

Work Phone: _____ Leave Message: (Y/N): _____

Email Address: _____

Occupation: _____ Employer: _____

Partner/Spouse Information (If Applicable):

Partner/Spouse Name: _____

Cell Phone: _____ Leave Message: (Y/N): _____

Emergency Contact:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Leave Message: (Y/N): _____

Relationship to Primary Client: _____

Referral:

How did you hear about Dayspring Behavioral Health?

Responsible Party/Guardian (If the client is a minor):

Name: _____ Date of Birth: _____

Social Security Number: ____-____-_____ Relationship to Client: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Leave Message: (Y/N): _____

Insurance Information:

Insurance Company: _____

ID Number: _____ Group Number: _____

Plan Name: _____ Employer: _____

Address of Insurance: _____

Billing Information Guidelines:

- Payment for all service fees, as outlined in the *Informed Consent* document, are to be paid in full by the above-mentioned "Responsible Party" at the time of service
- A $50 fee will be charged for appointments that are cancelled less than 24 hours in advance and missed appointments will be charged up to the full fee
- DBH accepts cash, check, and most major credit & HSA cards

By Signing below, you indicate that you have read the "*Billing Information Guidelines*", and have been offered a copy of the agreement. The signature represents a binding agreement between Dayspring Behavioral Health and the Responsible Party.

_____ _____

Printed Name of Client Signature of Client

_____ _____

Printed Name Responsible Party/Guardian Signature Responsible Party/Guardian

Date: _____

Credit Card on File Policy

Dayspring Behavioral Health is committed to reducing waste and inefficiency through making our billing process as simple and easy as possible. We require that you provide a credit card on file with our office.

CARD HOLDER NAME: _____
(EXACTLY AS IT APPEARS ON CREDIT CARD)

CARD NUMBER: _____
EXPIRATION DATE: _____ **CV Code:** _____ **Billing Zip Code:** _____

I authorize **Dayspring Behavioral Health** to keep my signature on file and to charge my credit card for the patient responsibility.

CARD HOLDER SIGNATURE: _____ DATE: _____

Credit Cards on file will be used to pay account balances:

- Credit cards will be charged at the time of service for your patient responsibility or the full fee if unknown unless an alternate form of payment has been provided (cash or check).
- Out-of-network insurances will be charged the full rate at time of service. Your account will be credited and adjusted if insurance reimburses our office.
- We have a 3% convenience fee for debit/credit/HSA/FSA cards.
- If your card expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.
- Ultimately, you are responsible for knowing what services are covered by your insurance company, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.

Credit Card on File Authorization

I agree to place my credit card on file to be run by Dayspring Behavioral Health. I authorize their staff to run my credit card for the purposes stated above.

Name of guarantor as it appears on the card: _____
Signature: _____ Date: _____

1700 NW Gilman Blvd, Suite 200
Issaquah, WA 98027
Office: (425) 295-7697
www.dayspringbehavioralhealth.com

Informed Consent & Insurance Addendum

Provider	Current In-Network Status (*Subject to change*)
Amy Ford	*Premera, Lifewise, Regence, First Choice Health, Group Health PPO, Aetna, Molina*
Carla Munger	*Premera, Lifewise, Regence, First Choice Health, Aetna*
Mary Brandenburg	*Premera, Lifewise, Regence, First Choice Health, Aetna*
Kristoffer Rouse	*Premera, Lifewise, Regence, First Choice Health, Aetna*
Karyn Ellis	*Premera, Lifewise, Regence, First Choice Health, Aetna*
Tina Candoo	*Premera, Regence, Aetna*
Aimee Bakeman	*Premera, Aetna, Molina*
Mary Anne Bennick	*Premera, Aetna, Molina*
Jed Savard	*Premera, Aetna, Molina*
Kelsey Kaskes	*Premera, Aetna, Molina*
Jessica Lazaro	*Premera, Aetna, Molina*

- **Insurance Billing:** We are happy to file a claim to your primary insurance company as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 30 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. *Any amount not covered by your insurance policy is due immediately after you receive your first invoice from us.*

- **Past Due Accounts:** Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

    - Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

- **Cancelations & "No Show" Appointments:** Insurance companies **DO NOT** reimburse for missed appointments. This charge is the responsibility of the client or guardian (in case of minor), and must be *paid in full* before future appointments will be scheduled.

- **Documentation & Phone Calls:** Most insurance companies **DO NOT** reimburse for written materials or phone calls. DBH **DOES NOT** submit claims for this service to the insurance company; the client/guardian is responsible for full payment.

- **Release and Assignment:** I give Dayspring Behavioral Health my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for various health care operations.

- **Informed Consent:** I have been informed that I may review Dayspring Behavioral Health's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that Dayspring Behavioral Health has a right to change their privacy practices and that I obtain any revised notices from Dayspring Behavioral Health.

- If you need assistance or have any questions, please contact our Billing Office between 8am and 5pm Monday-Friday at (208) 209-7341.

I have read and understand the "Informed Consent". I may request a copy of the signed "Informed Consent" at any point in time. The signature represents a binding agreement between Dayspring Behavioral Health and the client and/or Legal Guardian.

_____	_____
Signature of Client or Parent/Guardian	Date
_____	_____
Signature of Therapist	Date

Counseling Client Disclosure Information

Dayspring Behavioral Health (DBH) is committed to providing professional mental health counseling to all individuals in compliance with recognized Federal and Washington State regulations and guidelines. This INFORMED CONSENT is in accordance with Washington State legal statute RCW 18-205. DBH does not discriminate based on the established Federal classifications.

Therapeutic Process:

The counseling process promotes growth and helps clients to express their feelings in a safe, supportive, and non-judgmental environment. Counseling improves coping skills and assists clients in identifying alternative solutions to life issues. The process is not always an easy road, as there is often increased stress and anxiety when examining emotionally troubling or painful events. Often family and friends struggle with adjusting to the changes clients make throughout therapy. Finally, despite the time spent, there is no guarantee that counseling will be successful for everyone. However, despite the potential difficulties, counseling is a therapeutic process in which the benefits may far outweigh the risks.

Initial: _____

Availability (Appointments & Phone Calls):

Client appointments are available depending on the therapist's work schedule and current availability. All calls will be returned in the order in which they are received, with the exception of client crisis. If you need immediate assistance, please call the King County Crisis Line at (866) 427-4747 or in the event of an emergency situation, please call 911.

Initial: _____

Termination:

If at any point in time during the counseling process you would like to terminate services, Dayspring Behavioral Health can recommend another mental health professional. All outstanding professional fees will be due upon notice of termination. The therapist has the right to terminate the counseling relationship at any point in time, with every effort to provide a smooth transition to another mental health professional. If you have any questions about transition or the termination process, please contact the Washington State Department of Health at (360) 236-4700.

Initial: _____

Confidentiality:

Information shared verbally in sessions as well as written progress notes will be held in the strictest confidence, and will not be released without your written consent, excluding the following scenarios:

- ***Safety:*** If a client is in danger of harming self or others, disclosure will be made to the emergency contact on file, as well as any of the local medical, police, and community resources needed to ensure the safety f the client. Every attempt will be made to disclose information within the presence of the client (and with voluntary consent).

- ***Mandatory Reporting:*** If abuse or report of a crime committed against an elderly person or a minor is disclosed then it is required by law to report the information to the appropriate agency.

- ***Professional Consultation:*** A client case may be presented to other mental health counselors for the purpose of exploring alternative therapeutic techniques, identifying community resources, and mitigating client risk of harm. Personal client information is not included in the consultation.

- ***Counselor Absence:*** During periods in which the counselor is unavailable, another professional counselor will be selected to continue the therapeutic process and maintain the safety and wellbeing of the client. Only the client information and progress notes necessary to continue the counseling process will be disclosed during the period of absence. This practice is based on the American Counseling Association ethical guideline to "prohibit abandonment or neglect in counseling and make appropriate arrangements for the continuation of counseling" (ACA A. 11.a)

- ***Legal Mandate*:** In select cases, counseling records may be subpoenaed. This practice is required by law to disclose information pertaining to suspected child or elder abuse, and/or neglect, threatened harm to oneself or others, and disclosure that a crime will be or has been committed.

- ***Minors:*** In the case of safety and mandatory reporting, disclosure will be made to the parents/guardians on file. The progress of therapy for minors will be considered a part of family therapy and will be discussed as appropriate with parents and/or guardians.

Initial: _____

Cost & Fees:

- ***Rates:*** The rate for Dr. Amy Ford is $225 for the initial intake and $190 for follow up sessions. Mary Brandenburg, Carla Munger, Karyn Ellis, Kris Rouse, and Tina Candoo is $160 for the initial intake appointment, and $140 for individual client follow up sessions. The rate for Aimee Bakeman, Mary Anne Bennick, Jed Savard, Jessica Lazaro and Kelsey Kaskes are $120 for the initial intake appointment and $100 for follow up sessions.

- ***Documentation & Phone Calls:*** Telephone calls and email exceeding 15 minutes will be charged as a percentage of the individual's hourly rate. Letters of recommendation, such as school summaries and legal reports will be charged the individual session rate of the provider.

- ***Payments:*** All services are to be paid in full at each session; unless other arrangements have been made in writing. A $25.00 billing fee will be added to your account each month that your account is not paid on. If a partial payment or a *Credit Card Authorization Form* has not been received after the 3rd statement, the account will be sent to collections. If it becomes necessary to forward your account to collections, you will incur a $75.00 fee to cover clerical and processing costs.

- ***Cancellations:*** Appointments must be rescheduled or cancelled 24 hours prior to the appointment, or a $50 fee will be charged. Up to the **full rate** will be charged for a "No Show" appointment ($160/$140/$100/$50). This charge is the client or parent/guardian (in case of a minor) responsibility, and must be paid in full before future appointments will be scheduled. Your insurance is not liable for missed appointments and cannot be billed.

- ***NSF Checks:*** Checks returned for any reason will result in an additional $35 processing fee, in addition to the face value of the check. This fee must be paid prior to scheduling your next appointment.

- ***Deposition & Testimonies:*** The rate for legal depositions, requested either by the client or the client's attorney, is $750 for a maximum of 4 hours. Additional time required for the deposition will be billed at the rate of $150 per hour. The rate for a court appearance, with our without counselor testimony, is $1,500 per day. The fees must be paid in full 30 days prior to the scheduled deposition or trial, unless other arrangements have been made in writing. **NOTE: The party requesting the deposition or court appearance is responsible for payment.**

Initial: _____