MENTAL HEALTH BENEFITS PRE-DETERMINATION FORM

Your Name: ________________________________

Instructions for determining your Mental Health benefits

Please contact your insurance company and request the following information. Bring this form to your 1st session.

- Contact the insurance company via the "Customer Service" number on the back of your card or via the company's website.
- Request "Outpatient mental health benefits"
- Ask the representative if your mental health benefits are managed by a separate company (e.g. Magellan or Coresource). If so, ask for their contact information and contact that company for your benefits (Please write the name of that company on the line below).

____

Kenneth Gates and Associates is an IN Network Provider for Blue Cross/Blue Shield of Illinois and PHCS.

Additionally, Debbie Simpson is an IN Network provider for Aetna & Cigna

Note: Out of Network benefits are sometimes as good as In Network benefits. Even if we are out of your network, it is worthwhile to check the coverage.

- Is Kenneth Gates & Associates an In Network Provider? Yes _____ No ________
- Is Pre-Authorization required? Yes _________ No __________

  If yes, the Pre-authorization number is: ______________________________
- What is your annual deductible: ____________________

  To date, how much has been met ___________________
- What is your co-pay or co-insurance amount: ___________________________ (this is the amount you will be responsible for each visit, once your deductible is met)
- How many session do you have per year: ___________________
- Are there any pre-existing condition limitations: Yes __________ No _____________

In addition to this form, please bring a copy of your insurance card to your first session.

Thank You

KENNETH GATES AND ASSOCIATES
8600 US Rt. 14, Suite 110
Crystal Lake, IL 60012

Client Information

Last Name: ____________________

First Name: ____________________

Middle Initial: ______

Home Address: ____________________

City: ____________ State: __ Zip: ______

Home Phone: ____________________

Cell Phone: ____________________

Birth date: ______ Age: ______ Sex ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W

Email Address: ____________________

How were you referred to our practice? ____________________

____

Guarantor, If Other Than Client

The Parent/guardian requesting services for a child, and signs the authorization for treatment on the first visit, is the responsible payor. If payment of the account is to be someone other than the authorized signature, we need a signed letter stating that this individual does accept responsibility for payment of the account.

Last Name: ____________________

First Name: ____________________

Home Address: ____________________

City: ____________ State: __ Zip: ______

Home Phone: ____________________

Birth date: ______ Age: ______ Sex ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W

Relationship to Client: ____________________

Email Address: ____________________

Insurance Information

PRIMARY:

Insurance Company: ____________________

Mental Health Carrier: ____________________

ID #: ____________ Group #: ______

Name of Insured: ____________________

Relationship to Client: ____________________

Birth date: ____________________

Social Security #: ____________

Employer: ____________________

Work Phone: ____________________

****Please be advised, we will submit to your insurance company on your behalf however it is the client's responsibility to verify coverage and benefits for counseling services.****

SECONDARY (If Applicable):

Insurance Company: ____________________

ID #: ____________ Group #: ______

Name of Insured: ____________________

Relationship to Client: ____________________

Birth date: ____________________

Social Security #: ____________

Contact Phone: ____________________

For Office Use Only

Treating Clinician: ____________________

Primary Diagnosis: ____________________

Please continue on the back

Authorization to Release Information & Assignment of Benefits

Kenneth Gates and Associates (the practice) may disclose all or part of this client's records to any insurance company or association, either by mail or electronically, as may be necessary for the completion of all practice claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records. I understand that the information to be release may include information pertaining to mental or psychological related conditions and/or drug or alcohol abuse. A copy of this shall be as valid as the original.

I hereby authorize payment to Kenneth Gates and Associates benefits herein specified and otherwise payable to me for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. I hereby agree that in the event that medical coverage is not sufficient to apply to the indebtedness incurred, and should there be any money over and above that is necessary to pay this debt, I agree that said practice may apply coverage against any which is owed by myself, my spouse or legal dependents of myself or spouse at the time, to the practice. I hereby transfer all interest in and title to my reimbursement monies from my insurance company to the practice.

Client (age 13 & Older): ______________________________ **Parent/Guardian:** ___________________________________

Consent to Mental Health Treatment:

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety, confusion, sadness, grief and/or discomfort. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Your therapist is available to support you throughout the counseling process But, there are no guarantees as to what you will experience.

The first few sessions of therapy will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with your therapist. At the end of the evaluation period, your therapist will notify you if they believe that they are not the right therapist for you and, if so, will give you referrals to other practitioners whom they believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, please discuss them whenever they arise. If you believe your therapist is not the best fit for your needs, please let them know and they will assist you in finding other practitioners who may be better suited for your needs.

By signing this Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form and duly authorize Kenneth Gates and Associates to execute said terms. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I certify that the information provided on this form is correct to the best of my knowledge.

______________________________	____________________	______________________________
Client (age 13 & older)	**Date**	**Parent/Guardian**

KENNETH GATES AND ASSOCIATES
Client Credit Card Authorization

In an effort to better serve our clients and simplify your billing experience, our practice offers credit card/HSA card acceptance. Charge card information is filed with your confidential client information and kept secure.

OPTIONS

_____ I hereby authorize Kenneth Gates and Associates to make a **one time** charge for the balance currently due on my account for the amount of $________________________.

_____ I hereby authorize Kenneth Gates and Associates to charge my account automatically each month the amount due after insurance claims have been processed. Cards will be charged the **THIRD FRIDAY** of each month.

_____ I hereby authorize Kenneth Gates and Associates to charge my account automatically after each counseling visit in the amount of $____________________ (this is the amount of your co-pay or co-insurance). Cards will typically be charged the **FRIDAY or SATURDAY** following your counseling session.

PAYMENT INFORMATION

Client Name: ______________________________

Client Billing Address: ______________________________

____

Type of Card: ☐ VISA ☐ MasterCard ☐ DISCOVER NETWORK

Card Number: ______________________________

Expiration Date: ______________ Security Code: ______________

The undersigned guarantees performance of the financial provisions of this agreement.

This card is a(an): ☐ Credit Card ☐ Debit Card ☐ HSA Card

Card Holder Name: ______________________________

Signature of Card Holder: ______________________ Date: ______________

CHARGE POLICY

_____ (initial) Being the authorized cardholder by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed.

_____ (initial) Charges made for actual services performed by our office are non-refundable. In the event of pre-payment any unused funds will be refunded within 30 days.

_____ (initial) Kenneth Gates and Associates is not responsible for charges that result in a overdraw of the cardholders account. If there are concerns about this taking place, please use a different form of payment.

To receive a receipt of the charges processed please provide a valid email address:

____

KEN GATES AND ASSOCIATES

Preferred Payment Arrangement

I understand that I am responsible for co-pays, co-insurance and any portion of the fee not covered by my insurance company. I prefer to pay this cost through one of the following options. (please select one):

☐ Credit Card on file. If I select this option, a separate form will be provided to me so that I can provide my credit card or HSA information. Charges will be deducted directly from my account according to the payment schedule I select.

☐ Cash or check at the time of my visits. I understand that if I select this option, I may still be responsible for portions of the fee not covered by insurance. In that case, I will be billed for any outstanding balance.

☐ Receiving a monthly statement. If I select this option, there will be **a $10 charge** for statements sent to me. I will be responsible to pay the balance in full unless a payment arrangement has been established with my therapist.

____ ____________________

Client and/or Guarantor Print Name Date

Statement of Financial Responsibility

Thank you for choosing Ken Gates and Associates to be a part of your wellness care. Below we have summarized your financial responsibility. Please read carefully and address any questions you may have with your therapist.

General Policies

- Payment of fees, co-pays and/or co-insurance is expected at the time of service. We accept cash, credit cards and/or checks.
- Returned checks – if a check is returned to us as unpaid by your bank, we will apply a $25 fee to your account.
- The entire fee for sessions missed or cancelled less than 24 hours in advance will be charged to your account.
- If a monthly statement is issued, a $10 charge will be applied to your account. Payment in full is expected within 30 days of that billing date. A $5 fee will be charged for late or non-payment of the statement.
- If you so choose, we will keep your credit card on file and post charges on either a weekly or monthly basis. If you choose weekly, that charge will be posted on a Friday, if you choose monthly, that charge will be posted on the 3rd Friday of the month.
- A Patient Portal is available to our clients which allows you to access your account and make payment on-line.

Insurance

- This practice will submit insurance claims as a courtesy to you, however, it is your responsibility to verify coverage and benefit level. Additionally, this practice will not be responsible for disputed claims.

<u>PPO's</u>

- Co-pays are due at the time of your session, unless arrangements to have your fee charged to a credit card have been made.
- If you have a deductible - the full fee is due at the time of service until such deductible has been met. It is your responsibility to know what your deductible is. After a deductible has been met, co-insurance payments will then be due at the time of your session, unless arrangements to have your fee charged to a credit card have been made.
- If, at the first session, you do not know your insurance benefit information, you will be charged the full session fee. Refunds will then be made once the insurance information is gathered.

<u>HMO's</u>

- Ken Gates and Associates is NOT in-network providers for BCBS HMO. If you have an HMO, we require you to pay the full session up front. In most cases, your HMO will reimburse 50% of the session, at which time, we will issue you a refund. We will submit to the HMO on your behalf but it is your responsibility to contact the HMO to verify that the claims have been received and processed.

Responsible Parties

- In cases of divorce or separation, the parent authorizing treatment is the party responsible for payment in full. Arrangements to share the cost of treatment per any divorce decree is the responsibility of the authorizing parent. Ken Gates and Associates will NOT bill a non-authorizing parent nor be responsible for collecting payment from that parent.

I understand that I am responsible for payment of this account. I have read and understand the Statement of Financial Responsibility and agree to abide by its guidelines.

____ ____________________

Signed Client (or parent if Minor) Date

Kenneth Gates and Associates
8600 Route 14, Suite 110
Crystal Lake, IL 60012

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations, Including Confidentiality and Its Limits

I ____ understand that as part of my health care. Kenneth Gates and Associates originates and maintains paper and/or electronic records describing my health history, symptoms, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I can request a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Kenneth Gates and Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me.

I understand that I have the right to have information disclosed in the context of therapy held in the strictest of confidence and that information will not be shared outside the practice without my written consent. I also understand that there are limits to the Practice's legal obligation to hold that information in confidence. In cases where my therapist believes there is significant risk of harm to myself or others, or in cases in which my therapist believes abuse has taken place or is taking place to a child or an elderly person; my therapist may have an obligation to report such instances to the authorities. I also understand that, for the purpose of providing the best possible care, my therapist may consult with his or her colleagues within the practice regarding my case unless I request a restriction to that consultation.

☐ I wish to have the following restrictions to the use or disclosure of my health information:

☐ I fully understand and accept the terms of this consent.

Client's Signature: ____Date: _______________

KENNETH GATES AND ASSOCIATES

Informed Consent Addendum
For Phone or Video Chat Sessions

Here are some key issues regarding phone or video chat psychotherapy sessions. We do not do psychotherapy over text or email. When you sign this document, it will represent an agreement between you and your therapist to engage in therapy sessions using a video format. If you have any questions, please let your therapist know.

1. Confidentiality issues
    a. If you have Siri, Google Now, Alexa or any other digital assistant app on your phone, be sure they are off before your session and unplug any smart speakers in the room before your session. If they are on, they are always listening, violating your confidentiality.
    b. No method of technological communication can be guaranteed to be completely confidential. With any technology, there is always a small risk of hacking and therefore loss of confidentiality. However, be assured that we have taken all efforts to keep our technology secure and to utilize HIPPA compliant applications.
    c. We will not record your session and we ask that you agree not to either.
    d. You agree to maintain confidentiality on your end of the session by using secure wifi (not public) and having updated virus protection on any computer used
    e. At the time of your phone or video session, please be in a quiet place where you will not be distracted or interrupted, and your session will not be overheard.
    f. If you live with others, find a quiet room and close the door. Consider using another device to play white/fan noise just inside the door for increased privacy.

2. Potential risks and costs to phone or video chat sessions
    a. There may be less nonverbal communication than for an in-person session.
    b. With any technology, there is always the risk of being inadvertently disconnected. If our call or chat session is disrupted at any time, we will call you back. If the calling technology appears to be dysfunctional, we can email each other about another time to call.
    c. As with any psychotherapy session, you are ultimately responsible for payment. We suggest that you check with your health insurance policy to see whether phone or video chat sessions are covered. Please discuss this with your therapist further as needed.
3. We can have a phone or video chat session when we are both in Illinois or when either of us is in Georgia, Arizona, Utah, Nevada, Colorado, Nebraska or Missouri. Generally state laws require that the therapist be licensed in both states: the state where the therapist is, and the state where the client is, but legislative efforts are underway to allow practice between states, and the above states have passed this legislation.
4. If you are having an urgent concern, reach out to your therapist by email or phone. Do not use the video chat platform.

I understand the above information and I consent to using phone or video chat for psychotherapy. I understand that I can withdraw my consent to phone or video chat sessions at any time.

____________________________	____________________________	____ / ____ / ____
Signature	Printed Name	Date