TBT, LLC - Teton Behavior Therapy

New Client Policy

Thank you for choosing Teton Behavior Therapy. We are committed to building a successful relationship with you and your family. Please let us know if you have additional questions after reading this. We look forward to working with you!

Teton Behavior Therapy Location: Our Jackson office is at 1490 Gregory Lane, in the building on the corner of Gregory Lane and High School Road. The entrance is through the side door that faces Gregory Lane, **upstairs** on the left. Please park in the 2nd parking lot (the lot that is closest to the garage). Office hours are from 8am-6pm, although exceptions may be made. The main phone number is (307) 734-6040. The crisis phone number is (307) 200-9570 and is available 24 hours/day, 7 days/week. Our Victor office is at 10 S. Main Street.

TBT Services Provided: TBT provides mental health counseling, academic coaching, and support. Referrals are available when TBT is unable to provide a requested or needed service.

Payment Information: The first meeting (Intake/Initial Assessment) rate is $175. After the initial assessment the rate per session, observation, clinical conversation or consultation is $150 per 50-55 minutes or pro-rated in 15-minute increments. Take note that most often observations and clinical conversations are not billable to insurance, therefore families will be financially responsible. Crisis sessions/conversations may be billed at a higher rate. Sessions typically last 50-55 minutes as this gives us a few minutes to transition to the next individual or family. Academic coaching fees are different and will be discussed as needed. **If you have Medicaid, Medicare, Victim Services, or DFS coverage, then these fees may not apply to you.**

Insurance Claims: We are providers for Blue Cross Blue Shield, Allegiance-Cigna, Mountain Health Co-op, Wyoming Kidcare CHIP, and Wyoming Medicaid. If you utilize another insurance plan, you will be responsible for payment of each session at the time of the session and we can submit "superbills" electronically to your provider. Please complete the attached insurance documentation so we can be prepared to discuss your plan.

Client Financial Responsibility: If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, the client is responsible for payment. Co-payments, deductibles, co-insurance, and payment for non-covered services are due at the time of service. Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. We accept cash, checks, and all major credit cards.

Financial Assistance: We work with every family to make sure that finances do not stand in the way of getting them the help they are looking for. We are willing to set up a discount plan for clients in financial need. Please contact Sheila, our Billing Manager, at sheila@tetonbehaviortherapy.com or 317-979-6509 to review options for a discount plan.

Missed Appointments: The time of your appointment is reserved exclusively for you. We request the courtesy of a 24-hour notice of cancellation, although we understand illness and unexpected events happen. Missed appointments without notice will result in a charge from the practice.

Paperwork: Attached you will find the initial intake paperwork. You can print these out and bring them with you to your first session, or you can fill them out when you arrive.

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Consent to Treatment

I do hereby seek and consent for my child/self to take part in treatment by a TBT therapist. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop treatment with this therapist at any time. The only things I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)

_____(initial) I have read, understand, and agree to Teton Behavior Therapy's new client policy (Page 1).

_____(initial) I understand that the charge of $175 for the intake (first meeting) and $150 for each additional 50 minutes of therapy, observation, and consultation is due at time of session unless arrangements have been made with TBT regarding insurance. Cash, check, and credit cards are accepted. If I have Medicaid, Medicare, or Crime Victims Services, these fees may not apply to me.

_____ (initial) I understand that my credit card on file will be charged for co-pays/session fees (if checked as the preferred payment method). I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment. I know that my credit card on file may be charged if the therapist is not informed otherwise. I understand that if payment for the services I receive here is not made, the therapist may stop treatment.

_____(initial) I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive.

_____(initial) I hereby acknowledge that I have received and have been given an opportunity to read a copy of TBT's Notice of Privacy Practices (Pages 10-12). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact TBT, LLC at 307-734-6040.

Copy accepted by client _____ Copy kept by therapist _____

My signature below shows that I understand and agree with all of these statements.

Client's Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to Client: _____

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist's Signature: _____ Date: _____

Patient/Client refuses to acknowledge receipt _____

TBT, LLC - Teton Behavior Therapy

Payment/Insurance Information

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Preferred payment method for each session: cash/check credit card other: _____

Does client have Medicaid? Yes No If yes, Medicaid #_____

Is anyone in family receiving Crime Victims Services? Yes No

Would you like us to submit these claims to insurance? Yes No

****We require a credit card number to keep on file for convenience of co-pays, payment, or missed appointments (an email will be sent for missed appointment charges):**

_____(Initial) I approve of TBT charging this card for co-pays or session fees at the time of each session.

Credit card #_____

Name at it appears on card_____

Expiration: _____ CVV code: _____

Billing address and zip code _____

_____

Insurance Verification

Please supply us with a photocopy of the back and front of your insurance card or we can copy your card in the office in order to submit to your insurance.

Primary Insurance: We file claims with the client's insurance upon the submission of proof of insurance. If the client cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating client payment at time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the client and due upon receipt.

Please call your insurance company prior to your initial appointment. You can usually locate the phone number for Mental Health/Substance Abuse and/or Behavioral Health information on the back of your insurance card.

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Insurance Company Name: _____

Policy Holder's Name: _____ DOB of policy holder: _____

Address of policy holder (if different than clients's address):
_____

_____

Insured's ID: _____ Group ID: _____

Effective Date: _____ Telephone Number for Benefits: _____

****Copy of the front and back of insurance card is required.** *Copy received by clinician Yes No*

Please make sure to request outpatient mental health benefits when calling your insurance company for information. Ask and complete the following:

1. Does your insurance cover counseling by a Licensed Professional Counselor or Licensed Clinical Social Worker? Yes No

2. Is TBT, LLC - Teton Behavior Therapy - an in-network provider? Yes No
   If not, ask if your plan pays for out-of-network benefits. Yes No

3. Is there a deductible? Yes No

4. How much of the deductible has been met? _____

5. What is your co-pay or percentage you are expected to pay? _____

6. Is there a limit on visits per year? Yes No
   If so, how many visits per year are issued? _____ *How many have you used?* _____

7. Do the service limits run per traditional calendar year? Yes No
   If not, how does the year run? _____

8. If you have a co-pay or you still need to meet your deductible, how would you prefer to pay? All major credit cards, HSA, flex-savings account cards are accepted.

   Credit card on file Cash Check

Please feel free to call us before your session or during your first session to discuss any questions or concerns about insurance and payment.

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Client Information

Client's Name: _____ Birthdate: _____

Gender: _____ Age: _____ Soc. Sec. #: _____ Marital Status: _____

Employment or school attending: _____ Grade: _____

Mailing Address: _____

Physical Address: _____

City, State, Zip: _____

Client's Mobile Phone (if applicable): _____ May we leave a message? Yes No

Home Phone: _____

E-mail: _____

Please initial for text or email reminders: Text _____ Email _____

Responsible Party (required for minors)

Who is/are the primary legal guardian(s)? _____

Address if different than above: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email of one or both guardians: _____

Please initial for text or email reminders: Text _____ Email _____

Name and address if guardian does not reside with client: _____

Should we include this guardian in all communication? Yes No

Emergency Contact Information

Contact name: _____ Relationship: _____

Phone: _____

Contact name: _____ Relationship: _____

Phone: _____

TBT, LLC - Teton Behavior Therapy

Mailing: PO Box 2299, Jackson, WY 83001
Physical: 1490 Gregory Lane, Jackson, WY 83001
10 S. Main Street Victor, Idaho
Phone: 307-734-6040 No fax line- please email or mail.

Authorization for Release of Information

I, _____, authorize TBT, LLC to **release/obtain** information to/from the following individual(s) or organization(s) regarding:

_____ DOB:_____:

1. Primary Care Provider (Dr. or Pediatrician-Required if utilizing Medicaid) :_____

2. Dentist (Required if utilizing Medicaid):_____

3. School (if applicable)_____

4. Other/Name/Affiliation:_____

5. Other/Name/Affiliation:_____

Specific type of information to be released/obtained: academic or social/emotional information that could be helpful in coordinating mental health services and school success.
Other: _____

Purpose for release/receipt of information: Coordination of mental health and education services.

This consent expires on whichever of the following occurs first: Date:_____
Event: One month after the end of treatment Conditions: Written revocation by the client

I further agree to hold TBT, LLC harmless for any use of this information made by a recipient authorized under this release, recognizing that TBT, LLC will have no control over such use once the information is released.

My signature authorizes TBT, LLC to release and obtain information with the above agencies.

_____ _____
Client Date

_____
Parent/Guardian (if client is a minor, under age 18) Date

_____

For School purposes only:
I also agree to allow the therapist above to see my child at school and/or to pick up my child from school to go to and from the Teton Behavior Therapy office for scheduled counseling sessions.

_____
Parent Signature Date

TBT, LLC - Teton Behavior Therapy

Client History Form

Please state your main concerns: _____

_____

_____

_____

_____

Please list a few goals you would like to accomplish or address in therapy.

1. _____

2. _____

3. _____

Household Information

Who else lives in the client's household? Include names, ages, and information on the quality of relationship.

_____

_____

_____

Custody and parenting plan (circle, if applicable): Lives with both parents (biological or adoptive)

Single parent household Shared custody (parents in different households)

Other: _____

Please provide a copy of the separation or custody agreement to TBT, if applicable.

Medical History

Please note the age and any other pertinent information for the client's physical health history, including childhood developmental milestones: _____

_____

_____

_____

Physical and mental health medication history and current doses (include non-prescription medication): _____

_____

_____

Primary care medical professional: _____ Date of last appointment: _____

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Mood Rating Scale

Carefully consider which apply to yourself or your child. Circle the corresponding number. (Based on the Hamilton Rating Scale and APA Level-1 Cross-Cutting Symptom Measure.)

Depressed mood (sad, gloomy, forlorn)

1. Definitely not depressed

2. Not sure

3. Mild

4. Moderate (brief periods of unhappiness or no emotion)

5. Severe (often looks sad or withdrawn)

Weeping

1. Normal for age

2. Seems to cry more frequently than peers

3. Cries frequently

Self-esteem

1. Child describes self in mostly positive terms

2. Little or no evidence of lowered self esteem

3. Describes self in some positive and some negative terms

4. Positive and negative terms, but mostly negative

5. Refers to self in derogatory terms, or avoids the question

Morbid thinking (death, violence)

1. None apparent

2. Some morbid thoughts – related to actual events

3. Somewhat more than usual morbid thoughts

4. Elaborate or extensive morbid thinking

Social withdrawal

1. Enjoys good friendships with peers

2. Has several friends, not very close

3. Is passive in getting friends

4. Rejects opportunities for interaction

4. Does not relate to others

Expressive communication

1. Expresses self fairly well

2. Not very talkative, but will talk

3. Withdrawn, very reluctant to talk

Sleep

1. Occasional or no difficulty sleeping

2. Mild but frequent difficulty sleeping

3. Moderate difficulty sleeping almost every night

a. problem falling asleep

b. problem staying asleep

c. problem waking in morning

Disturbance of eating

1. No problem

2. Mild - Too little _____ Too much _____

3. Moderate - Too little ____ Too much ____

4. Extreme - Too little ____ Too much ____

Suicide and suicidal ideation
1. None apparent

2. Has thoughts of suicide – usually when angry

3. Recurrent thoughts of suicide

4. Thinks about suicide and names methods

5. Has recently attempted suicide

Irritability (whining, chip on shoulder, hostility)

1. Normal amount

2. Occasional – slightly more than normal

3. Episodic – comes and goes

4. Frequent

5. Constant

Schoolwork
1. Performing at or above expected level

2. Not working to capacity or recent disinterest

3. Doing poorly in most subjects or major decline

4. Incapable of doing schoolwork

Capacity to have fun

1. Interests and hobbies appropriate for age

2. Has interests but lacks enthusiasm

3. Easily bored, "nothing to do"

4. "Goes through the motions" without real interest or enthusiasm

5. No initiative, watches others or only TV, has to be coaxed to be involved in any activities

Form completed by: _____
Comments:

Frequent physical complaints (head, stomach)
1. No complaints

2. Occasional complaints but easily reassured

3. Frequent complaints

4. Preoccupied with aches and pains

Energy level
1. Normal

2. Occasional complaints of fatigue

3. Frequent complaints of being tired

Activity level
1. Activity at usual level

2. Slight reduction of activity level

3. Activity greatly reduced from usual or very slow in talking, walking, and other activity

In the past two weeks:

1. Had an alcoholic beverage (beer, wine, liquor, etc.)?
Yes No Don't know

2. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco
Yes No Don't know

3. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?
Yes No Don't know

4. Used any medicine without a doctor's prescription (e.g. painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?
Yes No Don't know

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Client's Rights and Responsibilities Statement

Statement of Client's Rights

Clients have the right to the following:

- To receive full information about their therapist's knowledge, skills, preparation, experience, and credentials.
- To be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
- To fully participate in all decisions related to their health care. If unable to fully participate in decisions related to health care, the client may be represented by parents, guardians, or other family members.
- To make final decisions regarding the recommendations of the therapist.
- To change to an alternative therapist if they so choose.
- To pursue a second opinion.
- To be involved in discharge planning from treatment beginning to termination.
- To submit complaints or grievances.
- To confidentiality. Any disclosure to another party will only be made with the knowing, written consent of the client and will be time limited, unless laws or ethics dictate otherwise. Entities receiving information for the purpose of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care. All client information is treated as private and confidential.
- To considerate, respectful care.
- To receive quality mental health services, which shall be provided to all individuals without regard to race, ethnicity, nationality, religious belief, gender, age, sexual orientation, or disability.

Statement of Client's Responsibilities

Clients are responsible for the following:

- For providing accurate and complete information about all matters pertaining to your health, including medications and past or present medical and/or mental health problems.
- For reporting changes in their condition or symptoms.
- To identifying and reporting any safety concerns that may affect your care.
- For asking if you do not understand information about your care or treatment.
- For informing their provider if unsatisfied with any aspect of their care.
- For participating in the planning of their care, including termination and discharge planning.
- For keeping scheduled appointments and canceling appointments 24 hours in advance.
- For full payment of services should their insurance company or 3rd party payer not provide payment.
- For paying their office co-pay or co-insurance as their benefits plan dictates.

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Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Jennifer Bradof, at PO Box 2299, Jackson, WY 83001 or call 307-734-6040.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me at Teton Behavior Therapy PO Box 2299, Jackson, WY 83001 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is March 2010.