MONTANA THERAPY CENTER

-PATIENTAPPLICATIONFORM -

Date _____ First Name: _____ Last Name: _____

Date of Birth _____ SS# _____ Sex:M _____ F _____

Married _____ Single _____ Living With _____ Divorced _____ Separated _____ Widowed _____ Minor _____

Partner First Name: _____ Last Name: _____ Date of Birth: _____

My Street Address _____ City _____ State _____ Zip _____

My Home Phone _____ My Cell# _____ Other _____

Employed: Full Time ___ Part Time ___ Employer _____

Emergency Contact: _____ Relationship _____ Phone# _____

Your Email: _____

Referred by:_____ Physician:_____

IF PATIENT IS A MINOR

Parent/Guardian: First Name _____ Last Name _____

Parent/Guardian Address _____ City _____ State ___ Zip _____

INSURANCE OR PAYMENT INFORMATION

**Please note if your provider is an intern or student and has a site supervisor, services cannot be submitted to insurance*

Fee for Service: Agreed Amount _____ Assigned Payee _____

Primary Insurance Company Name _____ Phone # _____

Insured Person's Name: _____ Insured Date of Birth _____

Insured Person's SSN or ID# _____ Group/Policy# _____

Relationship to Patient _____ Insured Employer _____

I have read the office policy regarding billing, appointments, and fees on the back page. I authorize the release of any medical or other information to process my claims. I understand that insurance may or may not cover part or all of my charges. I authorize payment of my insurance to be paid directly to the provider. I am responsible for all charges not covered by insurance and any fees that I may incur. In the unfortunate circumstance that we are forced to send your bill to collections, a *30% surcharge* will be added to cover the added costs. I authorize this for myself or any minor children that I am signing for.

_____

Responsible Party Signature Date

All Licensed Providers at Montana Therapy Center are Independent Practitioners

CONTACT@MT.CENTER
406.655.TALK (8255) (Fax)
406.794.0206

1645 Parkhill Dr.
Suite 1
Billings, MT 59102

MONTANA
THERAPY CENTER

Notice of Privacy – HIPAA
Please sign bottom after reading

This notice describes how health information about you as a client may be used and disclosed and how you can get access to your health information. This is required by the privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy: As independent providers we are dedicated to maintaining the privacy of your health information.
We are required by law to maintain the confidentiality of your health information. We realize these laws can be complicated, but we provide you with the following important information:

1. Use and disclosure of your health information in special circumstances: The following circumstances may require us to use or disclose your health information
    - To public health authorities and health oversight agencies that are authorized by law to collect Information
    - Lawsuits and similar proceedings in response to a court or administrative order
    - If required to do so by a law enforcement official
    - When necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual or public. We will only make disclosures to a person or organization able to help prevent the threat.
    - If you are a member of the US Military or foreign military forces including veterans, and if required by the appropriate authorities.
    - To federal officials for intelligence and National security activities as authorized by law.
    - To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
    - For workers compensation and similar programs

2. Your rights regarding your health information:
    - Communications. You can request that we as independent practitioners communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
    - You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. you have the right to request that we restrict our disclosure of your healthcare information to only individuals involved in your care or the payment for your care such as family members and friends. We are not required to agree to your request; however, if we do, we are bound by our agreement except when otherwise required by law In emergencies or when the Information is necessary to treat you.
    - You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical records or billing records but not including psychotherapy notes. You must submit your request in writing to your therapist.
    - You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to your therapist. You must include your reason for the request supporting the amendment.
    - Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.
    - Right to file a complaint. If you believe your rights have been violated, you may file a complaint with your therapist at 406-655-8255 or with the Secretary of the Department of Health and Human Services.
    - Right to provide authorization for other uses and disclosure. each therapist must obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or health information privacy policies, please contact your therapist.

I hereby acknowledge by my signature that I have been presented with a copy of Notice of Privacy Practices by my therapist.

Signature of client : _____
Date:_____

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THERAPY CENTER

Office Policy for Billing & Appointments

Each licensed therapist is independently incorporated and responsible for billing/record keeping for their own patients.

We individually outsource our billing accounts. We will submit the billing and will send you a statement of your account when you have a balance due. You are welcome to contact Med-Write at 406-655-0980 for any billing questions.

PAYMENT RESPONSIBILITY:

As a client I acknowledge that I am ultimately responsible for all charges not covered under my insurance, EAP, or Managed Care Plan including psychological testing, letters, phone calls, emails, court proceedings and all co-payments. I understand there will be a charge for No Shows and or unexcused cancels without 24 hour notice.

SUPERVISION: We may utilize confidential group or individual supervision with other independent practitioners as necessary.

List of Customary Charges:

- The customary fee for the initial interview is $250.00. Individual sessions $185.00 or the allowed billable fee established by your health insurance/managed care plan. A billable session includes all administrative time even if that happens outside of your session. Family counseling, couples counseling or group counseling, all have different rates. High deductible insurance policies may be handled on a fee for service basis.
- Please note if your provider is an intern or student and has a site supervisor, services cannot be submitted to insurance. Your provider will discuss the options for "Self Pay" and what their fee for service amount is.
- Any required co-payments, fee for service, or health savings accounts may be made at the end of your session. We can accept most credit and debit cards, HSA, checks or cash.
- You will be billed for missed appointments without 24 hour notification or “no shows”. Exceptions are illness or other immediate crisis, but notification needs to be provided ASAP.
- We charge a set fee for other professional services such as, psychological assessments, testing, reviewing testing, report writing, treatment summaries, phone conversations lasting over 10 minutes, attendance at meetings or consultation.
- Court proceedings are billed at $275/hour with a 3 hour minimum charge. This includes all subpoenaed activity i.e. depositions, file reviews, and court appearances. Since we have to clear out our schedules to appear, you will be charged even if we are not called to testify. We require 72hours notice for cancellations without charge on any appearance or deposition.
- We are willing to travel for depositions and court appearances. Our bill for this service will include any needed hotel stays and all meals plus travel time at $75/hour.
- Attorneys often want to speak with us. We will have you fill out a Release of Information (confidentiality) first. This will apply whether your attorney wants to speak with us in person, by phone, or any written from of communication. All attorney communications are charged at the same rate. $200/hour with a 15 minute minimum.
- We realize that there are letters and calls that will fall into our regular duties. We ask that these be kept to a minimum so that we can spend more time with our patients. When there are excessive requests for letters, phone calls, emails, etc, we will begin to charge for each of these. Your therapist will discuss this with you and you will be notified before the charges begin. All phone calls longer than 10 minutes will be charged for at a rate of $100/hour.
- If your bill is too large to pay for a given month, please ask your provider about a payment plan.

If you have any questions regarding our Office Policy for Billing and Appointments, please contact your therapist.

I hereby acknowledge by my signature that I have been presented with a copy of the Office Policy for Billing and Appointments by my therapist.

Signature of client : _____Date:_____