Family Behavioral Health Services, LLC

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Fax (440)460-5413
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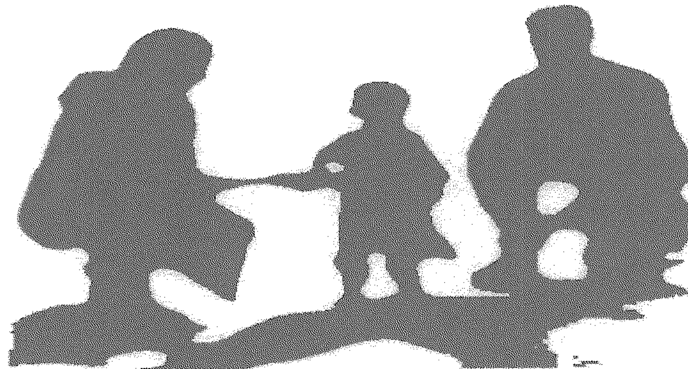
www.fbhsllc.com

WELCOME TO OUR PRACTICE



Client Information and Office Policy

New Client: Welcome!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

We require all of the included forms to be completed by the patient or guardian prior to your first appointment. Please read and complete all of the included forms and bring them with your insurance card to your first appointment. Do not mail them back to our office.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

I. Appointments:

Appointments are usually scheduled for 45 minutes. The Business office hours are Monday thru Friday 9:00a.m. to 5:00p.m. We offer appointments Monday thru Saturday 8:00 a.m. to 8:00p.m. You will need to check with your specific provider to find out their hours. Please check in at the window when you arrive for your appointment, if it is after business office hours please have a seat and your provider will be with you.

Parents and/or guardians must attend the first appointment with their minor child, some of our therapists/ psychiatrists prefer that the parents and/or guardians attend the first appointment alone, if you are not sure about your appointment please call our business office.

Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, your psychiatrist or therapist may be reached by pager at 440-460-0140. If you are unable to reach your psychiatrist or therapist and it is an emergency, you may call your primary care physician or 911.

When calling our office your call will be answered by our "phone mail" system. Please listen to the menu options and make your selection. All of our therapists/psychiatrists have confidential "phone mail" for times when they are with patients or out of the office. Please leave your name, phone number and a time that you will be available at that number. Please do not leave billing questions on your therapist/psychiatrists phone mail, the business office handles all billing issues. If you need to schedule or cancel an appointment please call the business office or leave a message on your therapist's phone mail

II. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1.) suspected abuse or neglect of a child, elderly person or a disabled person, 2.) when your psychiatrist or therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3.) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4.) if your psychiatrist or therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6.) In natural disasters whereby protected records may become exposed or 7.) When otherwise required by law. You may be asked to sign a Release of Information so that you therapist may speak with other mental health professionals or to family members.

III. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on site.

IV. Fees:

Fee for the initial visit is $200.00
Each 45 minute counseling session thereafter is $145.00
20-30 minute medication visits $100
1 hour medication visits $160.00
Requested letters $25 - $50
Summary of treatment/detailed report $75.00
Court appearances $250.00 an hour
Depositions $250.00
School Meetings $150.00
Phone calls with your provider longer than 5 minutes duration will be charged $25 for each 15 minute interval there after.
We will forward 1 copy of your records at no charge, any copies after that will be sent after a $10 copying fee is paid.
Additional work will be billed according to the amount of time involved.
Please check with the business office for fees for other services such as testing, Group, Reiki, Ect.

V. Payments:

Due too many changes with insurance carriers, it is your responsibility to understand your insurance coverage. Any services that we provide which are not covered by your insurance are your responsibility.

Self -Payment and Co-Payments are due at the time of the session unless other arrangements have been made. Our office will file your insurance claim, **but you are responsible for deductibles, co-insurance, and co-payments. If the business office is closed please give your provider your payment.**

Our office will not carry balances over $300.00 – If your balance is over $300 we will not schedule any further appointments until payment is made.

We reserve the right to take any required legal action to obtain payment on an overdue account. If your account is sent to our collection agency and their lawyers you will be responsible for all collection costs and court fees.

NSF checks are charged a $30.00 fee.

Please bring your insurance cards to your first appointment, and keep our office updated any time you receive a new card.

It is your responsibility to familiarize yourself with your insurance benefit.

IF YOU DO NOT GET PRIOR AUTHORIZATION YOU WILL BE RESPONSIBLE FOR THE VISIT.

Mental health benefits are different from your medical benefits and it's is important that you understand what your benefits cover. Many insurance companies require the patient or guardian to obtain pre-certification for the first visit, and will not allow our office to obtain this for you. Please ask your insurance Company the following questions and bring the information with you to your first appointment.

1. Do I have a deductible?
2. Do I have a maximum number of sessions?
3. Do I have a co-pay or co-insurance?
4. Do I need pre-certification?
5. Is the billing address the same as the one on my insurance card?
6. Is my provider in-network or out of network?

If your insurance requires pre-certification, please bring the authorization number that they give you to

your first appointment. Authorization will go under your provider's name, their supervisor or Family Behavioral Health Services. If the insurance is having a hard time locating the provider, please call our business office so that we can help determine if they are on the plan.

Medicare – You **do not** need to call Medicare they will pay a portion of the allowed charges and you or your secondary insurance will be responsible for the portion that Medicare sets as patient responsibility.

Medicaid – You **do not** need to call Medicaid, our office accepts Medicaid

Medicaid HMO'S – Must have Authorization from their PCP (Caresource, Anthem, Ect.) We are not on Buckeye Medicaid.

VI. Cancellations and Missed Appointments:
You will be billed for a sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. **You will be billed $75.00** --not just a co-payment. Insurance companies generally do not reimburse for failed appointments. **After three missed appointments, it will be at the therapist's discretion to schedule another appointment.**

VIII. PERSCRIPTION RENEWALS

If the following procedures are not used, your prescriptions will not be renewed.
If you are not following your doctor's treatment plan for follow-up appointments, your prescriptions will not be refilled.

Prescriptions are only refilled Monday - Friday 9:30 a.m. and 5:00 p.m.

For written prescription refills: 3 days notice is required

Call your doctors voicemail 440-460-0140, Email (pkontos@fbhsllc.com) or Fax (440)460-5413 our office with the following information:

Patient's name
Date of birth
If it is a 90 day RX
Full name of medicine
Amount you are taking and the directions of how you take it.

Controlled substance prescriptions (Ritalin, Adderall, Concerta, Focalin, Vyvanse, Etc.)

Patients who are on a controlled substance must be seen every 1-3 months depending on your treatment plan set up with your doctor. You will only receive prescriptions at your appointments. At the time of your appointment you will be given prescriptions. Take them to the pharmacy they will fill your first one and keep the rest on file. Lost or stolen prescriptions will not be replaced until it is due to be refilled. Please remember that our doctors' schedules book 6 weeks in advance.

For phoned in refills: 24 hour notice is required - We do not call the pharmacy

Please have your pharmacy call our office at 440-460-0140, fax 440-460-5413 or email pkontos@fbhsllc.com

You must set up with your pharmacy yourself to have prescriptions faxed to our office, we will not initiate faxed prescriptions.

Please check with your pharmacy after 48 hours, we do not call you back to tell you the prescription was called in.

DIRECTIONS TO OUR OFFICE

We are located on Wilson Mills Rd between 271 and Som Center Rd. Next to Austin's Steak House Restaurant, in Jefferson Park Complex. Our entrance is on the side of the 3rd building.

6559 C Wilson Mills Rd. Suite 102 Mayfield Village, Oh 44143

Family Behavioral Health Services, LLC
REGISTRATION FORM
(Please Print)

Provider: PK DM SM TG WTE LLE KCT SWK RAC GH SS	Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single Married Divorce Widow Partnered Other

Would you like to receive our e-newsletter? ❑ Yes ❑ No	Email:	Social Security #	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State	Zip Code

I authorize the following person to have access to my billing information. Name:	Spouse/Parent name:	Patient Cell phone # ( )	Patient Home phone # ( )
Patient Occupation:	Patient Employer:		Patient Employer phone # ( ) EXT

Chose clinic because/Referred to clinic by (please check one box):			❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) You must call your insurance to initialize authorization if it required.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone # ( )
Is this person a patient here? ❑ Yes ❑ No		Is Authorization required? ☐ Yes ☐ No	Authorization #

Occupation:	Employer:	Employer address:	Employer phone no # ( )

❑ I have no insurance and will be self-pay **$______________ payment is due at the time of service**

Please indicate primary insurance	❑ MMO	❑ Anthem	❑ Aetna	❑ Cigna	❑ Medicare
❑ Caresource	❑ Wellcare/Magellan	❑ Medicaid	❑ United Health/UBH	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no#:	Policy/ID #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Co-payment Amount: Yearly Deductible Amount:	**I have an Employee Assistance Program and will be using those benefits prior to my insurance.** **EAP Phone #**	EAP Authorization #	# of Authorized visits

Please indicate EAP Company	☐ Anthem	☐Magellan	☐Cigna	☐ UBH	☐ Horizon	☐ Carebridge
☐ Wellpoint	☐ Value Options	☐ Aetna	☐ BHS	☐ Ease	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize FBHS or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Consent for Purposes of Treatment, Payment, Operations and Acknowledgment of Privacy Practices

THIS CONSENT PERTAINS TO SERVICES RENDERED BY FBHS & APPLIES TO ALL PROVIDER SERVICES, EMPLOYEES & AGENTS OF FBHS

I CONSENT TO THE USE OR DISCLOSURE OF MY/OR MY MINOR CHILD'S "PROTECTED HEALTH INFORMATION" BY ALL FBHS PROVIDERS, EMPLOYEES & AGENTS FOR THE PURPOSE OF DIAGNOSING OR PROVIDING TREATMENT TO ME OR MY MINOR CHILD, OBTAINING PAYMENT FOR MY HEALTH CARE BILLS OR TO CONDUCT ANY AND ALL HEALTH CARE OPERATIONS OF FBHS. I UNDERSTAND THAT DIAGNOSIS OR TREATMENT OF ME OR MY MINOR CHILD BY, ANY FBHS PROVIDER MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS FORM.

I UNDERSTAND I HAVE THE RIGHT TO REQUEST IN WRITING RESTRICTIONS AS TO HOW MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS OF THE PRACTICE. FBHS IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST, IF FBHS AGREES TO THE RESTRICTIONS I REQUEST, THE RESTRICTION IS BINDING ON FBHS.

I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT FBHS HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT. I UNDERSTAND THAT I MUST PAY FOR ANY AND ALL CHARGES FOR TREATMENT IF I REFUSE TO AUTHORIZE THE DISCLOSURE OF ANY PROTECTED HEALTH INFORMATION AND IT RESULTS IN DENIAL OF PAYMENT.

MY " PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PROVIDER, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER, OR A HEALTH CARE CLEARING HOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT AND FUTURE PHYSICAL, MENTAL HEALTH OR CONDITION AND IDENTIFIES ME, OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME.

I UNDERSTAND AND I ACKNOWLEDGE THAT I HAVE READ FBHS NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. FBHS'S NOTICE OF PRIVACY PRACTICES IS AVAILABLE TO ME ANYTIME UPON MY REQUEST. THE NOTICE OF PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT WILL OCCUR IN MY TREATMENT, PAYMENT OF MY BILLS OR IN THE PERFORMANCE OF THE HEALTH CARE OPERATIONS OF FBHS. THE NOTICE OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND THE FBHS'S DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. FBHCC RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN A REVISED COPY BY CALLING THE OFFICE OR ASKING FOR IT AT MY NEXT APPOINTMENT.

I UNDERSTAND THAT I MAY OBTAIN A COPY OF FBHS PRIVACY PRACTICES BY REQUESTING IT FROM THE BUSINESS OFFICE OR MY PROVIDER, READING IT ONLINE AT WWW.FBHSLLC.COM OR IN THE OFFICE WAITING ROOM. I DO NOT HAVE ANY QUESTIONS REGARDING FBHS'S PRIVACY PRACTICES OR THE RELEASE OF MY PROTECTED HEALTH INFORMATION.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED IS COMPLETE AND CORRECT.

I AM THE PATIENT OR REPRESENTATIVE AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ THE ABOVE AND UNDERSTAND ITS TERMS.

____ ____________________

SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE DATE

____

RELATIONSHIP TO PATIENT

Policies and Procedures of Family Behavioral Health Services, LLC

I understand that it is my responsibility to know my insurance benefits and coverage, and to notify the office if my insurance changes.

The patient/guardian hereby acknowledges that she/he has been informed that the following health care services may need pre-authorization or referral. I understand that if I do not get authorization I will be responsible for any and all charges that insurance does not cover.

I understand that I am financially responsible for any and all charges to FBHS and their providers for all services rendered to the above named patient from the beginning of services until discharge, regardless of insurance coverage.

The patient/guardian also understands that it is their responsibility to contact their insurance company for authorization and PCP for referrals.

The patient/guardian understands that if they wait the insurance company may not back date this authorization or referrals and that therefore the patient/guardian agrees that he/she will bear full financial responsibility for payment of all charges for these services.

I understand that FBHS requires 24 hours notification for all cancelled appointments and I will be charged $75 for late cancellations or no shows. After 3 missed appointments it is up to my provider's discretion to schedule another appointment with me.

I understand that co-payments and self-payments need to be made at the time of service and FBHS reserves the right to refuse treatment without it.

I understand that FBHS reserves the right to notify my insurance company that I have broken my contractual agreement with them if I do not pay my co-pays at the time of service.

I understand that FBHS will not carry balances over $300.00. If my balance exceeds $300.00 my treatment may be terminated until it is paid.

I understand that there will be a $30.00 charge for checks returned NSF by my bank, and that FBHS may refuse to accept checks from me after 2 NSF checks.

I understand that FBHS reserves the right to send my delinquent account to a collection agency and their attorneys. I agree that I will be responsible for all court costs, reasonable attorney fees and all other collection expenses. I authorize that in this process protected health information may be released to all contractors who carry out, assist in the performance of, or perform of the collections process.

I have received a copy and have read FBHS's Client information and policies. I understand all of the policies and agree to abide by them.

I have received a copy of FBHS's Privacy Practices Notice.

FBHS reserves the right to change their polices, and will post any policy changes in their waiting room. My signature on this form, states that I have read and completely understand the policies and procedures of FBHS.

____ ____/____/____

SIGNATURE OF PATIENT, GUARDIAN OR REPRESENTATIVE PRINT NAME DATE

CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

DEMOGRAPHIC INFORMATION

Client Name: ______________________________ Date: ______________
First M.I. Last

Date of Birth: ________________ Age: ______ Gender: Male Female

Who has legal custody of this Child? ______________________________

Who referred you to our practice? ______________________________

Name of pediatrician: ______________________________

May we contact them to coordinate care? ______________________________

Address: ______________________________ Phone: ______________

FAMILY/SOCIAL HISTORY

Mothers/Guardians Name: ______________________________
First Last Maiden

Address: ______________________________

Home Phone: ______________________ Work Phone: ______________________

Occupation: ______________________ Employer ______________________

Fathers/Guardians Name: ______________________________
First Last

Address: ______________________________

Home Phone: ______________________ Work Phone: ______________________

Occupation: ______________________ Employer: ______________________

Are Parents Divorced? Yes No

EDUCATIONAL/VOCATIONAL HISTORY

School: ______________________________ Grade Level ______________

Does the child attend special education classes? Yes No

If yes, please list ______________________________

CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

PRESENTING PROBLEM

Why are you seeking counseling at this time?

____

____

____

____

____

____

Please list any prior mental health or substance abuse treatments:

Date	Reason for Treatment	Facility or Therapist	Inpatient or Outpatient

Please list any medications prescribed currently or in the past for any mental health problems:

Date	Name of Medication	Dosage	Date of Last Dosage

MEDICAL HISTORY

Date of last physical Exam:____

Do and biological relatives have any mental health conditions? Yes No

If yes, please list conditions: ____

Has the child ever been hospitalized for a medical condition? Yes No

Year	Hospital	Reason for Hospitalization	Outcome

CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

Does the child **currently** take any medications for a medical condition? Yes No

Medication Name	Purpose of Medication

Allergies: Does the child have any allergies (drug/ food/ seasonal)?:

____

____

DEVELOPMENTAL HISTORY

Pregnancy: Full Term Premature Other ____________________

Any complications? Yes No Unknown

If yes, please describe: ____________________

Was the child's speech development within normal limits? Yes No Unknown

Was the child's motor development within normal limits? Yes No Unknown

Part I : Please answer the following questions by circling Yes or No.

Has the child ever been physically hurt or threatened? .... Yes No

Has the child ever been sexually abused? .... Yes No

Does the family currently have guns in the home? .... Yes No

Part II: Does the child often exhibit any of the following behaviors or feelings?

Does not seem to listen .... Yes No

Has difficulty keeping self organized .... Yes No

Forgetfulness .... Yes No

Loses things .... Yes No

Is easily distracted .... Yes No

Has trouble with attention to details .... Yes No

Has trouble with sustained attention .... Yes No

Avoids tasks that require mental effort .... Yes No

Fails to finish tasks or projects .... Yes No

Is fidgety / restless .... Yes No

Talks excessively .... Yes No

Leaves seat when remaining seated is expected .... Yes No

Runs around or climbs excessively .... Yes No

Has problems playing quietly .... Yes No

Interrupts or intrudes on others .... Yes No

In school, often blurts out answers without being called on .... Yes No

CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

Difficulty waiting turn .... Yes No
Frequently seems angry or has a bad attitude .... Yes No
Frequently argues with (*circle all that apply*) parents, siblings, peers, or teachers .... Yes No
Takes things that do not belong to him / her .... Yes No
Often physically fights with (*circle all that apply*) parents, siblings, peers, or teachers ,,,,,, Yes No
Has been cruel to pets and/or other animals .... Yes No
Has run away from home .... Yes No
Often skips school .... Yes No
Has destroyed property .... Yes No
Has set fires .... Yes No
Do you feel your child is depressed? .... Yes No
Has difficulty falling asleep or staying asleep .... Yes No
Eating habits have changed (*circle which applies*) decreased appetite / increased appetite .... Yes No
Talked about wanting to hurt themselves .... Yes No
Has attempted suicide .... Yes No
Has ever had a time, a week or longer, when (s)he was feeling so good, high, excited or hyper that (s)he got into trouble? .... Yes No
Experiences significant and persistent worry that is difficult to control .... Yes No
Frequently experiences intrusive unwanted thoughts .... Yes No
Exhibits repetitive behaviors or mental acts in an attempt to reduce anxiety (*circle all that apply*)
hand washing, counting, cleaning, checking, ... Yes No

Part III:

Has your son child been involved with the police or juvenile court for any reason? Yes No
Explain: ______________________________

____

Do you suspect your child is using drugs or alcohol? Yes No Explain: ______________________________

____

____

Please describe any unusual family events or crisis that have taken place in the past year. ______________________________

____

____

In what areas do you and your spouse differ where raising children is concerned? ______________________________

____

____

Briefly describe any other current marital difficulties. ______________________________

____

____

____
Parent or Legal Guardian Signature Date