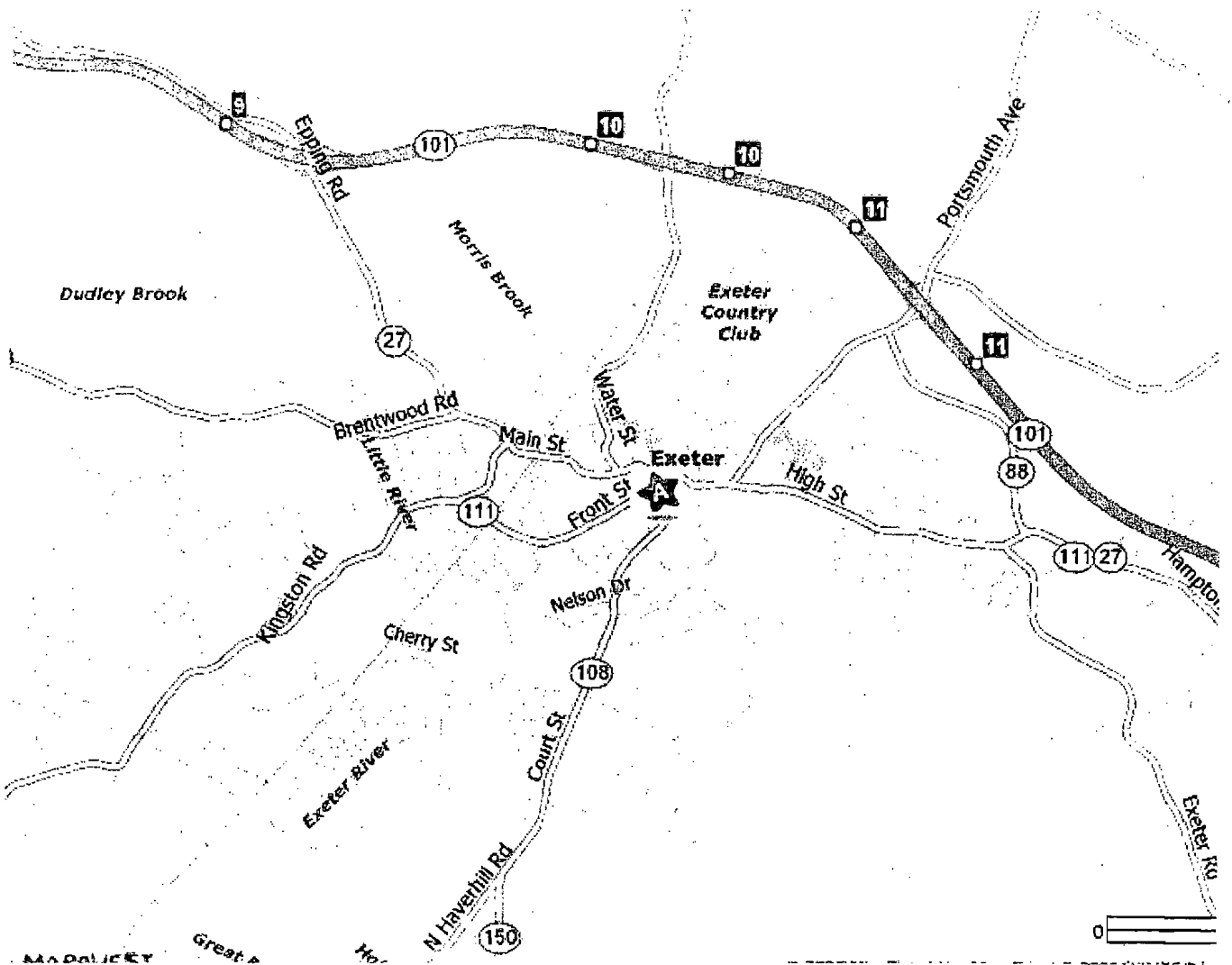


COASTAL COUNSELING ASSOCIATES

** 24 FRONT STREET EXETER, NH 03833 (603) 778-0505



Office Location

24 Front Street Exeter, NH 03833 (corner of Front St and Court St)

Second Floor. Take a left around stairwell and you will see a sign for Business Office over the door. Please check in prior to your appointment and have paperwork signed in three places and completed or it will take time from your appt.

Parking: Municipal lot diagonal to rear of Coastal Counseling Associates: all Street parking is either ½ hour or 2 hour maximum. Please check the signs. Do not Park behind CCA building since parking is for tenants only and your vehicle may be towed.

COASTAL COUNSELING PATIENT REGISTRATION FORM

Doctor/Therapist _____

Date First Appt. _____ Time: _____

PATIENT INFORMATION:

First Name: _____ M: _____ Last Name: _____

Address Line 1: _____ Telephone: _____

Address Line 2: _____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Sex: _____ Marital Status: _____

Social Security #: _____ Primary Provider: _____

Who may we thank for this referral: _____

.....
BILLING INFORMATION:

First Name: _____ M: _____ Last Name: _____

Address: _____ Telephone #: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Social Security #: _____

.....
INSURANCE INFORMATION:

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Relationship to Insured: _____

Employer Name: _____ Telephone: _____

Insurance Company Telephone Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Relationship to Insured: _____

Insurance Company Telephone Number: _____

.....
X _____ X: _____
Signature of Patient or Parent Date

COASTAL COUNSELING ASSOCIATES

24 FRONT STREET

EXETER, NEW HAMPSHIRE 03833

TELEPHONE (603) 778-0505

FAX (603) 772-6761

PATIENTS NAME _____ DR. /THERAPIST _____

Effective date of new coverage: _____

Below is a list of questions to help you to verify your insurance benefits and facilitate the billing process. It is necessary that you provide this information prior to your first appointment. If **not completed** we will bill the subscriber. Patients/Clients are responsible to get the **initial authorization**.

1. Please verify whether or not you need pre-authorization for outpatient mental health.

Yes _____ No _____

2. If so, what is your Authorization Number?

3. Number of sessions authorized _____

Date: From _____ To: _____

4. Maximum sessions or total amount of sessions allowed per year.

5. Co-pay Due: _____

ADDRESS (**PLEASE ASK WHERE TO SEND MENTAL HEALTH CLAIMS**):

INSURANCE PHONE NUMBER: _____

CONTACT PERSON: _____

THANK YOU FOR YOUR COOPERATION.

COASTAL COUNSELING ASSOCIATES
24 FRONT STREET
EXETER, NH 03833
(603)-778-0505 FAX (603)-772-6761

POLICIES AND PROCEDURES AND CONSENT TO TREATMENT

Welcome to Coastal Counseling Associates (CCA). We at CCA believe that therapy is a collaborative process in which both client and provider must work together to achieve established goals and to assume responsibility for insuring a smooth delivery of services. The Board of Mental Health Practice regulations require that all licensed mental health professionals provide certain basic information. Also, it is our hope that providing information about our practice will help to reduce the possibility of a confusion or misunderstanding. Please take the time to read and review our policies and procedures carefully before signing below, since your signature indicates both your understanding and acceptance. If you have any specific questions you can either call our Office Manager, Michele, or discuss them with your therapist or doctor at your first appointment.

License and Code of Ethics

The State of New Hampshire licenses all practitioners at CCA to practice in their specialty areas. We are also governed by a Code of Ethics a copy of which can be reviewed at the front desk.

Bill of Rights

A copy of the mental health bill of rights is posted in the waiting room and front office. Please review and raise any questions you may have.

Confidentiality and Limits of Confidentiality

Under NH law, whatever is discussed in therapy is confidential and may not be disclosed without the specific authorization of the client except under specific limited circumstances.

1. Confidentiality ceases to exist in cases where there is evidence that a person is a danger to themselves or others or in cases where ongoing abuse is occurring. For example, if it is suspected that a child, an elderly or a disabled person is being abused or neglected, a report must be filed with the appropriate state agency. Also, if a client threatens to seriously harm another person we are required to take appropriate actions that may include notifying the potential victim, notifying the police, and or seeking hospitalization for the client.
2. Health care professionals are required to release records when subpoenaed by a court of law.
3. Parents or legal guardians of minors have a right to review their records.
4. At times, psychotherapists discuss cases with a professional peer supervisory group of senior therapist consultant. In the consultations every effort is made to keep the client's identity confidential. The consultant is legally bound to confidentiality as well.

5. Authorizations to release clinical information to insurance companies and primary care physicians may be necessary in order to access insurance benefits. Records may also be subject to audit by regulatory authorities. If you have any questions about confidentiality please speak to your therapist/doctor.

6. Treatment records of couple's sessions contain information about each client. Therefore, both clients must understand and agree that treatment records will not be released without a court order.

7. When fees for service are not paid in a timely manner, collection agencies and or small claims court may be utilized to collect unpaid debts. The amount owed, time frame, and the name of the agency may be reported during this process, but specific information such as diagnosis, treatment plan and/or notes will not be disclosed.

Emergency Coverage

Emergency coverage is provided on a 24 hour basis through our emergency voice mail system. Please discuss this procedure with your therapist or doctor.

Financial Policies

As a service to you. CCA will bill insurance companies and other third-party payers, but we cannot guarantee benefits or amounts covered and are not responsible for collection of such payments.

The person responsible for payment, (the undersigned) is responsible for all charges, including deductible, co-pays, and all services not covered by insurance, due at time of service.

It is **your responsibility** to verify your insurance benefits and to obtain any necessary pre-authorization prior to your first appointment.

Rates for specific services can be obtained from your therapist or at the front desk. Certain services, including school meetings, consultations, court appearances, travel time, letters and reports, telephone conversations over 15 minutes and no-shows cannot be billed to insurance and must be paid by the responsible party.

24-hour notice is required for all cancellations in order to avoid a charge. Monday appointments should be cancelled on Friday. Frequent cancellations may result in discontinuation of services. Clients will be billed for all no shows and payment is due before the next schedule appointment.

Payments not received after 120 days are subject to collections or small claims court and you may be held responsible for any associated fees.

Questions regarding the financial policies can be answered by your clinician or by the Office Manger.

Patient Agreement:

I (we) have read and understand CCA's policies and procedures and consent to treatment for myself and or my minor child/children. I (we) also authorize CCA to release any or all information necessary to process my insurance claim and authorize insurance payments to be made directly to CCA. I understand that I am responsible for all unpaid balances.

Signature(parent or guardian)_____

Date: _____

COASTAL COUNSELING ASSOCIATES

24 FRONT STREET

EXETER, NEW HAMPSHIRE 03833

TELEPHONE (603) 778-0505

Fax (603) 772-6761

CCA: PRIVACY NOTICE

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND READ CCA'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTION REGARDING THE NOTICE OR MY PRIVACY RIGHTS I CAN CONTACT CCA'S PRIVACY OFFICER AT 24 FRONT STREET, EXETER, NH.

Signature of client/patient

Date

Signature of Parent or Guardian

*** Client refuses to acknowledge receipt:

Signature of Staff

Date

COASTAL COUNSELING ASSOCIATES

Effective: September 24, 2009

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 CLIENT FILE MAY CONTAIN PERSONAL INFORMATION ABOUT YOUR HEALTH AND/OR THE HEALTH OF YOUR CHILDREN. THIS INFORMATION MAY IDENTIFY YOU 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. 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. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR PRIVACY PRACTICES AND WILL INFORM YOU IF WE DO SO.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

For Services: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members.

For Business Operations: We may use or disclose as needed your PHI in order to support our business activities such as confirming appointments, coverage, billing, accounting, collections, quality assurance and utilization review. We do require that outside consultants sign a privacy contract to help insure confidentiality.

All other uses and disclosures of PHI will be made only with your written authorization with the following exceptions:

- When required by law, such as the mandatory reporting of child abuse or neglect, imminent
- Danger or mandatory audits from government agencies or boards.
- Required by court order

YOUR RIGHTS REGARDING YOUR PHI

- The right to request restrictions on certain uses and disclosures including those to family
- Members, other relatives, close friends or other identified by you. We are, however, not
- Required to agree to a request restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI
- The right to inspect and copy of PHI
- The right to request an amendment of your PHI
- The right to receive an accounting of disclosures of PHI
- The right to obtain a paper copy of this notice from us upon request

COMPLAINTS: If you believe we have violated your privacy rights you have the right to file a complaint in writing with CCA'S PRIVACY OFFICER or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C.
