Growing Hope Counseling, Inc.
1217 3rd St South
Suite 103
Nampa, ID 83651
208.606.2783

CLIENT INFORMATION

Client Name: _____

(Last) (First) (Middle Initial)

Mailing Address: _____

Phone #: _____-_____-_____ Email:_____

Preferred Method of Contact (By selecting text or email you are consenting to the communication of medical information over electronic mediums that are not considered to be confidential): ☐ Text ☐ Phone ☐ Email

Date of Birth: ____/_____/_____ Sex: ☐ Male ☐ Female

Social Security Number: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widow ☐Partner

Occupation: ☐Full Time ☐Part Time ☐Unemployed ☐Full Time Student ☐Part Time Student

Name of Employer/School:_____

Previous Mental Health Care (last 2yrs): ☐Psychiatrist ☐Psychologist ☐LPC/LCPC ☐LCSW ☐Other

MH Provider Name:_____ Phone: _____-_____-_____

Type of Counseling Interested In:

☐ Pre-Marital Counseling☐ Individual Counseling ☐ Couples Counseling

☐ Family Counseling ☐ Spiritual Counsel

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INSURANCE AUTHORIZATION FORM

Primary Insurance Company Name: _____

ID Policy #: _____ Group #:_____

Claims Address: _____

Phone #: _____-_____-_____ Co-pay Amount: $_____

Policy holder's Name (Last, First MI.): _____

Date of Birth: _____/_____/_____ Social Security #: _____
Month Day Year

Effective Date of Insurance: ____ /____/____
Month Day Year

Policy Holder's Employer: _____ Phone #: _____- _____-_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other _____

Date of Birth: ____/_____/_____ Phone # _____-_____-_____
Month Day Year

Name (if different from patient):_____

Secondary Insurance (Medicare Patients only) _____

ID Policy # _____ Policy Holder Name: _____

Date of birth: _____/_____/_____
Month Day Year

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize Growing Hope Counseling Inc. to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____

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OUTPATIENT SERVICE CONTRACT

THERAPISTS INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in counseling, you have certain rights that are important for you to know about because this is your therapy, and our goal is your well-being. There are also certain limitations to those rights that you should be aware of. As therapists, we have corresponding responsibilities to you.

FEES FOR SERVICE

Our "Private Pay" fee schedule, per session, is as follows:

- Pre-Marital counseling (45 min): $50 per session, or $210 paid in advance for 6 sessions
- Individual counseling (50 min): $105 per session
- Couples counseling (90 min): $135, initial session is $180 for a 2 hrs session
- Family Counseling (60 min): $105 per session
- Spiritual Counsel (45 min): $65 per session

If we decide to meet for a longer session, we will bill you prorated on the hourly fee. Telephone calls or emails up to 5 minutes are provided at no charge but will accrue an additional prorated charge of the hourly rate.

We are not willing to have clients carry a balance. Major credit cards are accepted.

Overdue bills will be charged 1% per month (12% per annum) interest.

If you refuse to pay your outstanding balance, we reserve the right to provide your name and the amount due to a collection agency.

Full Fee will be charged for not appearing at your scheduled appointment time or failing to notify at least 24 hours in advance of a cancellation.

I understand the above statement. _____ (Initials)

CRISIS INFORMATION

Growing Hope Counseling does not provide crisis intervention. Instead, we give crisis information to our clients at the beginning of treatment. In the event of a crisis, please call the Crisis Hot Line Idaho at 208-788-3596 (208-578-4114 bilingual), Idaho Suicide Prevention Hotline at 800-273-8255 or dial 911.

QUESTIONS OR COMPLAINTS

If you are unhappy with what is happening in therapy, we hope you will discuss it with us so that we can respond to your concerns. We will take such criticism seriously, and with care and respect. If you believe that we have been unwilling to listen and respond, or that we have behaved unethically, you can complain about our behavior to the Examining Board for Counseling, Boise, ID. You are also free to discuss your complaints about us with anyone you wish, and do not have any responsibility to maintain confidentiality about what we do that you do not like, since you are the person who has the right to decide what you want kept confidential.

CLINICIAN AVAILABILITY

The clinician will be available to you, in person, during your normal scheduled sessions, and by email or telephone during normal posted business hours (between other client sessions). The clinician will attempt to return non-emergency missed contact within 24 hours.

To allow the client to prepare themselves and make necessary arrangements, the clinician will be unavailable during the following times of the year:

- The ten (10) US recognized Federal Holidays
- Two (2), but up to three (3) weeks during the summer months (Jun - Aug)
- One (1) surrounding the day of Christmas
- One (1) week during the public school system spring break season

The clinician will notify the client at least 3 weeks prior to the absence.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept "“friend” or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telehealth by the State of Idaho. Under the Idaho Telehealth Act of 2015, telehealth services are broadly defined as healthcare services provided by a provider to a person by use of electronic communications, information technology, asynchronous store and forward transfer or synchronous interaction between a provider at a distant site and a patient at an originating site.

If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine.

Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also from direct visual and olfactory observations, information, and experiences.

When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

NON-DISCRIMINATION POLICY

Growing Hope Counseling does not discriminate against any person because of race, color, national origin, sex, income, age, religion, creed, marital status, sexual orientation, or the presence of any physical, mental, or sensory disability. No person shall on the grounds of race, color, national origin, sex, or age be excluded from participation in any counseling programs or other services provided by the therapist.

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 50 – 60 minutes (unless otherwise stated). It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist so that we can schedule time in advance, which will be billed at an additional pro-rated cost.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that allotted session time.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are ultimately responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience, and will be happy to help you in understanding the information you receive from your insurance company. Unfortunately, due to the time involved in dealing with most insurance companies, I am not able to help you negotiate or advocate for your benefits directly with your insurance company.

Due to the rising cost of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to obtain authorization for additional sessions after a certain number of sessions. While a great deal can be accomplished in short-term therapy, some patients feel that they require additional services after insurance benefits end. Some managed care plans will not allow me to provide services to you once your benefits end.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes they require additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will then become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with your information once it is in their hands. In some cases, they may share the information with a national medical information databank.

Once we determine the benefits available to you through your insurance coverage, we will discuss what we can expect to accomplish with the benefits available, and what will happen if benefits run out before you feel ready to end treatment. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

TERMINATION OF THERAPY

You always have the right to terminate therapy. Because significant feelings about the therapeutic relationship can develop during the course of therapy, I strongly suggest that we discuss the issue of termination before actually terminating our therapeutic relationship. Should you decide that you wish to continue therapy with someone else, I will gladly provide you with contact information or resources for other mental health professionals who may be helpful. It is always your right to request this.

CONSULTATION

I may occasionally find it helpful to consult with other professionals about your treatment. During the consultation, I make every effort to keep any identifying information regarding my patients confidential.

The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is relevant or important for our work together.

I HAVE READ, UNDERSTAND, AND AGREE TO THESE POLICIES.

_____ _____

Signature **Date**

Growing Hope Counseling, Inc.
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CLIENT CONSENT FOR THERAPY

I, _____, authorize and request that Bruce Pagano II, LPC provide mental health counseling/psychotherapy services.

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it.

I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process.

I agree to pay the identified fee of the applicable counseling service received, unless otherwise adjusted in writing.

I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Bruce Pagano II, LPC.

I understand that I can terminate therapy at any time I wish and that I can refuse any requests or suggestions made by the therapist. I am over the age of 14.

BY SIGNING I AM ACCEPTING AND CONSENTING TO PSYCHOTHERAPY AND ALL THE ABOVE-IDENTIFIED TERMS.

_____ _____

Signature **Date**

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FINANCIAL AGREEMENT

Please understand that you are financially responsible for your treatment and that payment is expected when services are rendered.

You will be provided with a receipt or invoice to obtain reimbursement from your managed care or insurance company if necessary.

NOTE: Your insurance will not reimburse for missed appointments or cancellations without 24 hours notice.

I authorize Bruce Pagano II, LPC (Growing Hope Counseling) to use my credit card for payment (or insurance co-pay) of ongoing sessions, including missed appointments and cancellations without 24 hours notice, and unpaid balances, until termination of treatment or my explicit written request to stop billing.

If there is a missed appointment or a cancellation without 24 hour-notice, or an unpaid balance, I authorize Bruce Pagano II, LPC (Growing Hope Counseling) to use the credit card below for payment.

I understand that I am responsible for notifying Growing Hope Counseling, Inc. if my credit/debit card information needs to be updated.

Growing Hope Counseling, Inc. agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance.

I understand that if I wish to cancel an appointment, I will need to speak with my counselor, send an email to the correct email address of my counselor, or leave a recorded voicemail message at or send a text message to 208.606.2783.

Name as Printed on Card: _____

Credit Card Number: _____ Expiration Date: _____

CVC 3- or 4-Digit Code: _____ Billing Address Zip Code: _____

Type of Card: ☐Visa ☐Mastercard ☐Discover ☐Other:_____

CLIENT PRINTED NAME: _____ DATE:_____

CLIENT SIGNATURE: _____

GROWING HOPE
COUNSELING

NOTICE OF PRIVACY PRACTICES

Growing Hope Counseling Inc
1217 3rd St S, Suite 103, Nampa, ID 83687
208.606.2783

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

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures, I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have a direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without

the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in the diagnosis and treatment of your mental healthcondition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful processes by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. RECORD KEEPING

1. We keep very brief records, noting only that you have been here, what interventions happened in the session, and the topics that were discussed. If you prefer that we keep no records, you must give us a written request to this effect for your file and we will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that we correct any errors in your file. You have the right to request that we make a copy of your file available to any other health care provider at your written request. We maintain your records in a secure location that cannot be accessed by anyone else.

2. An audio recording is taken of each session for strictly record-keeping and note-taking. The e-file is recorded on a password protected device and transferred to an external hard drive that is secure in a locked location. There is no personal information connected to the e-file. You have the right to request that the session not berecorded.

IV. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group,

joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose yourPHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

V. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health-related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment

alternatives, or other health care services or benefits that I offer.

VI. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or another person that you indicate is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VII. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Use and Disclosure of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for in Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing

within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on May 1, 2020 Acknowledgment of Receipt of Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

PRINTED NAME DATE

_____

SIGNATURE