Megan W. Spinks, LCSW, ACSW, Inc.
6408 Constitution Drive
Fort Wayne, IN 46804
Phone: 260/459-0990 Fax: 260/459-0282

Patient Information

Patient Name: _____ Gender: __ Male __ Female

Address: _____
Street/Box# City State Zip

Home Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____

Work Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____

Cellular Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____

Marital Status: __ S __ M __ D __ W Patient Employer: _____

Patient Date of Birth: _____ Patient Age: _____

Primary Care Physician: _____ Permission to Contact Physician: __ Y __ N

Primary Insurance Information

Insured's Name (if different from above): _____

Insured's Address: _____
Street/Box# City State Zip

Insured's Social Security #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance ID #: _____ Group # _____

Secondary Insurance Information

Insured's Name (if different from above): _____

Insured's Address: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance ID #: _____ Group # _____

If Child Is Identified Patient/ Client

Father's Name: _____ Step Father: _____

Mother's Name: _____ Step Mother: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

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Fort Wayne, IN 46804

Cancellation Policy

Cancellations for scheduled appointments require a 24 Hour notice. If 24 hours is not given you will be charged the full session fee of $90.00. A no show for an appointment will result in a full session fee of $90.00.

Patient Name: _____

Social Media/Electronic Communication Policy

FRIENDING

I cannot accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @ replies, or other means of engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Please note that if you do choose to utilize SMS to communicate with me I cannot guarantee the confidentiality of these messages. If you do utilize SMS please do only for administrative reasons, such as to change or confirm an appointment.

If you need to contact me between sessions, the best way to do so is by phone (260-459-0990). Email is not set up to guarantee privacy of your personal medical record. If you choose to send information through email, please understand I do not have a secure server per HIPPA guidelines.

EMAIL

I prefer using my email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of you and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become part of your legal record.

I have read and understand the social media policy. If I choose to have appt or content sent to me via email/text the following email address/text number can be used with my understanding the sites are not secure

Email Communication Address: _____

Text Communication Number: _____

_____ _____

Responsible Party Signature: Date:

_____ _____

Signature:/Witness Date:

Megan W. Spinks, LCSW, ACSW, Inc.
6408 Constitution Drive Fort Wayne, In 46804
(260) 459-0990 Fax: 459-0282

Consent for Services

Please initial and sign below consenting for treatment of mental health services.

_____ **Responsibility for Charges Incurred**

All insurance co-pays, co-insurance, and/or deductible amounts are due at the time of service. I agree that I am responsible for charges incurred after all insurance payments have been made. I understand I am responsible for the entire amount of services in the event I do not provide accurate information related to my insurance information. I understand that there is a $30.00 return check fee charge.

_____ **Agreement to Pay**

In consideration for the services rendered and to be rendered by Megan W. Spinks, LCSW, ACSW Inc. to the below mentioned patient, I agree to pay Megan W. Spinks, LCSW, ACSW, Inc. for all services and charges in accordance with the terms and policies of Megan W. Spinks, LCSW, ACSW, Inc. I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made or within sixty (60) days from the date of service and it is necessary to place this account in the hands of a collection agency, to pay cost of collections which includes: 35% of the outstanding balance, court costs, collection fees and interest from the date of demand.

_____ **Assignment of Payment**

I assign all treatment benefits which are due for services to Megan W. Spinks, LCSW, ACSW, Inc. be paid directly to Megan W. Spinks, LCSW, ACSW, Inc.

_____ **Failed Appointment Charges**

I understand that 24-hour notice is required for cancellation of appointments. A failed or no show appointment is defined as a cancellation that is not done within 24 hours of the appointed time. I understand that if I fail to cancel my appointment within 24 hours or if I do not show for a scheduled appointment, I am responsible for the full $90.00 fee for the session, which will be due prior to the next scheduled appointment.

_____ **Treatment of Choice**

I understand that I have chosen to be involved in counseling services. I have the right to be actively involved in my treatment goals and can ask questions at any time. I understand that I may terminate treatment at any time.

_____ **Use of Recording Devices**

I agree to refrain from use of audio taping or video recording during sessions/services with Megan W. Spinks, LCSW, ACSW, Inc. as there are various legal and ethical issues related to confidentiality.

_____ **Additional Fees**

I understand there will be a charge for any letters/summaries requested related to my care. This includes letters to schools, attorneys, and outside professionals. I understand fees for consultation to attorneys will occur.

_____ **Release of Medical Information**

I authorize, Megan W. Spinks, LCSW, ACSW, Inc. to release necessary medical information to the appropriate third parties for reimbursement purposes and/or persons authorized to conduct utilization review services. I have been offered a copy of HIPPA Rules and Regulations.

I agree and consent to participate in services provided by Megan W. Spinks, LCSW, ACSW Inc. as defined by the laws of Indiana. I understand that I am consenting and agreeing to counseling services by a licensed counselor in the state of Indiana.

Patient Name if child: _____

Client/Responsible Party: _____ Date: _____

Witness: _____ Date: _____

Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW THE CLIENT MAY ACCESS THIS INFORMATION.

I: Uses and Disclosures for Treatment, Payment, and Health Care Options

Protected Health Information (PHI) may be used for treatment, payment, and health care operations purposes with client consent.

- *Treatment* refers to coordination, management of your health care, and other services related to your health care.
- *Payment* refers to sharing information for the purpose of facilitating payment from your insurance carrier.
- *Health care operations* refer to activities that relate to the improving performance and operation of the practice.
- *Use* refers to activities within the office/practice.
- *Disclosure* refers to activities outside of the office/practice such as transferring or providing information about you to other parties.
- *Authorization* refers to written permission to disclose confidential mental health information. All authorizations to disclose information must be signed on a designated form specifically identifying the information to be released.

II: Other Uses and Disclosures Requiring Authorization

PHI may be used for purposes outside of treatment, payment, or health care operations with appropriate authorization by the patient are obtained. Authorization will be obtained for release of information for purposes outside of treatment, payment, or health care operations prior to release of this information.

The client has the right to revoke all authorizations of PHI or progress notes at any time, provided each revocation in writing. The client does not have the right to revoke authorization that will impact the condition of obtaining insurance coverage and reimbursement. The law provides the insurer the right to contest the claim under the policy.

III: Uses and Disclosures with Neither Consent nor Authorization

Mental health professionals my use or disclose PHI without your consent or authorization in the following circumstances:

- *Child abuse*—if a child is believed to be a victim of child abuse or neglect a report to the appropriate authorities is required.
- *Adult and domestic abuse*—if an adult is believed to be a victim of abuse and could be danger a report to the appropriate authorities must occur.
- *Health oversight activities*—If the Indiana Attorney General's office is conducting an investigation into this practice, disclosure is required of PHI upon receipt of a subpoena.
- *Judicial and Administrative proceedings*— medical/mental health information is protected under state law. Information will not be released without written authorization for release of information. The privilege does not apply when evaluation for a third party or where the evaluation is court ordered. The client will be informed in this circumstance.
- *Serious threat to health or safety*—a threat of violence to cause serious injury or death against a reasonably identifiable victim or victims will result in a report to the appropriate authorities. Evidence conduct or statements indicating an imminent danger that the client will use physical violence or use other means to cause personal injury or death to others requires this practice to report to the appropriate authorities. If there is reason to believe that the client is in serious threat or harm or death this information may be required to be reported to the appropriate authorities.
- *Worker's compensation*—PHI regarding worker's compensation necessary for evaluation will be released as established by the law. The benefits for work-related injuries or illness without regard to fault will be released.

IV: Patient's Rights and Mental Health Professional's Duties

Patient's Rights

- Right to request restrictions—the client may request restrictions on certain uses and disclosure of PHI. The practice is not required to agree to a restriction requested.
- Right to received confidential communication by alternative measure and alternative locations—the client has the right to request and receive confidential communication of PHI by the by alternative means at alternative locations.
- Right to inspect and copy—the client has the right to inspect or obtain a copy of PHI in a mental health and billing records used to make decisions about the client as long as the PHI record is maintained. Mental health records can be denies release in certain circumstances under specific laws.
- Right to amend—The client has the right to request an amendment of PHI for as long as the PHI is maintained in the record. The practice may deny your request.
- Right to an accounting—The client has the right to received an accounting of disclosure of PHI.
- Right to a paper copy—the client has the right to obtain a paper copy of the notices from the practice.

Mental Health Professional Responsibilities:

- The mental health professional is required to maintain the privacy of PHI and to provide the client with a notice of legal duties and privacy practices with respect to PHI.
- The mental health professional has the right to change the privacy policies and practices as described in this notices. Privacy guidelines will be followed as established by the appropriate authorities.
- A copy of any revisions in the privacy policies and procedures will be provided to the client.

V: Questions and Complaints

If the client has questions about this notice, disagrees with a decision made about access to the clients recorded, or have other concerns about privacy rights he/she may contact the practice at 260-615-3547 or 260-348-5474.

If the client believes that his/her privacy right have been violated and wish to file a complaint with the practice, he/she must do so in writing to the practice. A note may also be sent to the Secretary of the U.S. Department of Health and Human Services.

The client has specific rights under the Privacy Rule. The practice will not retaliate against the client for exercising his/her right to file a complaint.

VI: Effective Date: This notice will go into effect on April 14, 2003.

Megan W. Spinks, LCSW, ACSW, Inc.
Authorization for Release/ Exchange of Information

Client Name: _____

Date of Birth:_____

Information Release/ Exchange From:
Facility: Megan W. Spinks, LCSW, ACSW
Address: 6408 Constitution Drive
Fort Wayne, IN 46804
(260) 459-0990

Information Release/ Exchange to:
Facility/Person: _____
Address: _____
Phone :(____) _____

__Intake Education
__Assessment/diagnosis
__Compliance/ Attendance
__Medical Records
__Treatment Recommendations
__Attendance
__Treatment Plan
__Recommendations

__ Progress Notes
__ Progress Reports
__ Medical Tests
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Prognosis
__ Discharge summary; prognosis
__Other (specify) _____

_____

Purpose or need for such Release/ Exchange of Information: _____

_____

_____

Authorization to Release/Exchange Information:
I understand that this authorization shall remain in effect for 180 days from the date of my signature below, unless an earlier expiration date is specified in this space ( ). I also understand that except to the extent that action has already been taken based upon this authorization, I may revoke this consent at any time by written notification to this agency.

I herby authorize the release and /or exchange of the above identifying information from my records. I hereby release Megan W. Spinks, LCSW,ACSW, Inc. from all legal responsibility or liability that may arise from this authorization.

_____

Authorizing Person Signature: Date:

_____

Parent or Guardian Signature: Date:

_____

Witness/Clinician Signature: Date:

_____

This information has been disclosed to you from the records protected by Federal Confidentiality Rules (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of this person to whom it pertains or as other wise permitted by 42CFR, part 2. A general authorization is not sufficient for this purpose. The federal rules restrict any of the information to criminally investigate or prosecute any alcohol or drug consumer.

Thank you for your interest in telehealth sessions. In the weeks ahead, please regularly check your phone and/or email for scheduling updates or changes, and if needed please respond in a timely manner. I will do my best to do the same! Also, please be sure that your voicemail is not full. Telehealth sessions require a camera/webcam, working microphone, and your ability to achieve privacy in your environment.

Insurance and Billing:

Please contact your insurance company about your specific plan benefits. It is important to verify that they will cover telehealth sessions. Most insurance companies appear to be making the necessary changes and waivers to make this happen. Be sure to specify "behavioral health" and if they request a CPT code, please provide the number 90791 and 90837. At the end of session, please prepare your payment which can be done by sending a personal check or sending a check directly from your bank.

Consent:

A new consent must be completed for telehealth sessions. ***Please do this before our first session.*** I request that if you have access to a printer, please print the attached consent, review, ***initial/complete all blanks, and sign***. Please email me a picture of your signed consent. After our session, please mail or fax (260.459.0282) me this form. My address and fax number are listed underneath my email signature below.

If *you do not have access to a printer*, I will need you to send me an email stating the following:

-you have reviewed the consent

-list the appropriate number for emergencies and appropriate number to call for technology failure (could be the same number)

-you consent and agree to all terms

-type your full name and the date you reviewed the consent

***I encourage the use of computers or tablets for the telehealth sessions; therefore we may communicate via phone if something goes wrong.

Telehealth Sessions:

Here is the link to use for sessions: **will be given at confirmation of appt via email.**

Click this link a couple minutes before our session begins and "check in" to my waiting room. Then please wait for my video call.

Thank you for allowing me to part of this journey we are on.

Megan W. Spinks, LCSW, ACSW, Inc.
6408 Constitution Drive Fort Wayne, In 46804
(260) 459-0990 Fax: 459-0282

Tele-Mental Health Informed Consent

Introduction of Tele-mental Health:
_____ As a patient receiving mental health services through tele-mental health technologies, I understand:

_____ Tele-mental health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

_____ The interactive technologies used in tele-mental health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:
_____ Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:
_____ This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Billing & Financial Responsibility:
_____ I understand all efforts will be made to bill my health insurance for tele-mental health services. I understand I am responsible for charges incurred for the telebehavioral health services based on my insurance plan.

Technology Requirements:
_____ I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. My practitioner will inform me of the technology to be used and how I will enter the tele-mental health session.

Exchange of Information:
_____ The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

_____ During my tele-mental health session, details of my medical history and personal health information may be discussed with myself or other mental/behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:
_____ If a need for direct, in-person services arises, it is my responsibility to contact my practitioner to determine the best course of action or I may contact Parkview Behavioral Health Assessment Center at (260) 373-7500, or St. Joseph Behavioral Health at (260) 425-3606. I also understand I can call 911 in emergency situations or proceed to my nearest emergency room.

Self-Termination:
_____ I may decline any tele-mental health services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology:
_____ These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:
_____ My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:
_____ In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

In emergency situations contact number of patient _____

Location of client:
____ It is understood that when participating in tele-mental health session that my location will be the address of record for me unless otherwise identified by myself the client and at that time, I will identify the address of my location.

Disruption of Service:
_____ Should service be disrupted practitioner should call _____

Practitioner Communication:
_____ My practitioner may utilize alternative means of communication in the following circumstances:

_____ Tele-mental session was disrupted due to internet failure of any form.

_____ Poor reception preventing effective communication.

Client Communication:
_____ It is my responsibility to maintain privacy on the patient end of communication. Insurance companies, those authorized by the patient, and those permitted by law may also have access to records or communications.

_____I agree I will not audio or video tape the telebehavioral session

Storage:
_____My communication exchanged with my practitioner will be documented by the practitioner in the form of a progress note placed in my medical record.

Laws & Standards:
_____ The laws and professional standards that apply to in-person mental/behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Confirmation of Agreement:

_____
Client Printed Name

_____
Signature of Client or Legal Guardian Date

_____
Printed Name of Practitioner Signature of Practitioner Date: