Emerald Isle Counseling

Allyn D Robb Jr. EDS, NCC, LPC Genie Nall LPC Denise Schuster LPC Mary Barns LPC
Aubrie Reedy LPC Alison Jimenez LPC Michael Gilliard LAPC Jennifer Sears LAPC
Aaron Coots LCSW

Dear Parent:

Please find the paperwork required for your upcoming appointment with Emerald Isle Counseling, Inc. Paperwork should be completed prior to appointment.

In addition to this paperwork, please bring your child's insurance card and your identification card. It is necessary that we have copies for our files.
Important: If you have not contacted your insurance company, please do so to determine if a referral and preauthorization is needed. Additionally, find out if your deductible has been met and if co-pay is applicable for services rendered.
Practice policy requires us to collect co-pays or deductibles the day of the appointment. If you are cash pay client, please be prepared to pay in full at the time of service. Personal checks and credit cards (including 3% processing fee) are accepted.

On the day of your appointment, please report to our office and wait in the assigned area. Your therapist will meet you there.

Thank you for allowing us to be your service provider and we look forward to meeting you.

Respectfully,

Judy A Watterson

Practice Manager
Emerald Isle Counseling

300 Oak St Su 203
St Simons Island GA
31522

PHONE 912-268-4750
FAX 888-837-0039
E-MAIL info@emeraldislecounseling.com
WEBSITE www.emeraldislecounseling.com

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Dear Client:

Welcome to Emerald Isle Counseling. We are pleased you selected our practice as your child's service provider. To receive the full benefits of their counseling experience, we strongly suggest that you:

A. See they attend their sessions regularly. Be committed to the program
B. Be honest with yourself, your child and your therapist about concerns that led you to seek therapy
C. Establish realistic goals and outcomes
D. Regularly discuss their progress with your therapist
E. Modify your goals as needed
F. Have you child be well prepared for their sessions. Complete any assignments
G. Be willing to honestly evaluate their progress or lack thereof
H. Participate honestly and fully

Counseling is a journey of self-examination and discovery. During this journey, if you are committed to your child making their appointments, they will build as a person, they will enhance their emotional awareness, you will see personal growth and you and they will learn how to constructively deal will non-productive or self-destructive thoughts, emotions and behaviors. Essentially, they will be acquiring a new set of tools to build a healthier and happier life.

Good Luck!

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Practice Protocols

***Phone Contacts*:**	**912-268-4750**	***Judy Watterson/ Christina McCormick***
Scheduling: **All scheduling/Changes Cancellations**	**912-268-4750**	***Judy Watterson-practicemanageremeraldisle@gmail.com*** ***Christina McCormick cmccormickeic@gmail.com***
Billing-Insurance:	**912-268-4750**	***Judy Watterson-practicemanageremeraldisle@gmail.com*** ***Christina McCormick cmccormickeic@gmail.com***

Financial Responsibility: Please be prepared to make co-pay or deductible payment at time of service. Be sure to contact your insurance company for information. Cancellation fee (less than 24 hours notice) is $50.00

Dear Clients:
We are thrilled you selected us to be your service provider; Emerald Isle Counseling. We will rely on your email, voicemail and other means of electronic media when Contacting you. Please utilize our website for contact whenever possible. Phone calls and messages will be addressed in 24 hours. Matters of an urgent nature should be so identified: Follow phone message with an email to Practice Manager when possible.
Thank You

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Emerald Isle Counseling LLC

Client Information

Child's Name_____DOB_____Gender_____

Mother's Name: _____ Father's Name: _____

Stepmother's Name: _____ Stepfather's Name: _____

Address_____City_____Zip_____

Home Phone_____Mobile Phone_____

Work Phone _____ Email Address_____@_____

Child's Social Security Number _____

Parent/Guardian's Social Security Number _____

Emergency Contact Name_____Number_____

Insurance Company_____ Policy_____

Group Number_____Group Name_____

Company Address_____Provider Phone #_____

Deductible_____Co-pay _____

Name of Insured_____Relation_____DOB_____

Appointment Reminders: The preferred method of appointment reminders is email 24 hours prior to appointment. However, if you do not have regular access to email, please provide a PREFERRED phone number.

Cancellations of less than a 24 hr notice and/or missed appointments WILL INCUR A $50 NO SHOW FEE

Names of siblings, their DOB and gender:

Name:_____DOB:_____Gender:_____

Name:_____DOB:_____Gender:_____

Name:_____DOB:_____Gender:_____

Presenting Problems:
Why is your child here? _____
_____

How do you want us to help?
_____
_____

What is your child's strong point in solving problems?
_____
_____

Has your child had any thoughts in the past or currently about self-harm (cutting behaviors) or suicide? ( ) Yes ( ) No
If yes, please explain:
_____
_____

Describe any major health issues and medication therapy (include sleep, digestive issues and head trauma)_____
_____

Does your child currently have any legal issues or involvement with Department of Family and Children Services? ( ) Yes ( ) No
If so please explain._____
_____
Does your child have any activities or interest ( ) Yes ( ) No
If so please explain._____
_____

FAMILY ORIGIN:
Are biological parents married? ( ) Yes ( ) No
If divorced, how old was your child when parents divorced?_____

If the child was not raised by birth parents, who raised the child?
_____

Has anyone in the immediate family died? _____

Does anyone in your family have a problem with alcohol/drugs, mental health problems? Yes ( ) No ( )
Other problems _____

NUCLEAR FAMILY:

- **How would you describe the relationship between siblings?**

  ____Cold ____ distant ___Loving ____close ___Stormy ____arguments

  ___Abusive ____verbal or physical abuse ___Tolerant ____put up with each other

- **How would you describe the relationship between mother (female guardian) and child?**

  ___Cold _____distant ___Loving ___close ___Stormy ____arguments

  ___Tolerant ____ put up with each other ___Abusive _____verbal or physical abuse

- **How would you describe the relationship between father (male guardian) and child?**

  ___Cold ____distant ___Loving ____close ___Stormy ____arguments

  ___Tolerant ____put up with each other ___Abusive ____verbal or physical abuse

SCHOOL:
What grade is child in? _____ Has child ever repeated a grade? Yes ( ) No ( )

What kind of grades do they usually make? ____A's ____B's ____C's ____D's ____F's

What is their favorite subject? _____

What school activities do they participate in? _____

What community activities do they participate in? _____

WORK:
Do they work? If yes, please explain:
_____
_____

RELIGION: Do they attend church? Yes ( ) No ( ) what church do they attend? _____

HEALTH: How is the child's health? __Excellent __Good __Fair __Poor

Has the child ever been admitted to a hospital? ___Yes ___ No If yes, when? _____

What were they treated for _____

List any medications they are taking:
_____

Emerald Isle Counseling LLC

Has your child ever seen a professional therapist (Counselor, Psychiatrist, Social Worker) Yes ( ) No ( )

ALCOHOL/DRUGS: Check any of the following which apply to the child:

__I do not use drugs at all
__I have used drugs in the past
__I drink but do not get drunk
__I drink when I feel a lot of pressure
__It helps

__I do not drink alcohol at all
__I have had some problems with drinking
__I can drink more now than in the past
__I have been told by someone I have a problem with alcohol
__It doesn't help

BEHAVIOR:
Words that describe the child's usual behaviors

__Overeating	**__Vomiting**	**__Work too hard**	**__Odd behavior**	**__Often put things off**
__Sexual problem	**__Crying**	**__Lose control**	**__Stay by myself**	**__Problems with friends**
__Job problems	**__Can't eat**	**__Get mad often**	**__Sleep all the time**	**__Do things over and over**
__Suicide attempt	**__Hurt self**	**__Can't sleep**	**__Get in trouble at school**	**__Act without thinking**

FEELINGS:
Most of the time they feel

__Anger	**__Confused**	**__Anxious**	**__Guilt**	**__Bored**	**__Depressed**	**__Full of energy**
__Ashamed	**__Fearful**	**__Helpless**	**__Sad**	**__Sorry**	**__Unhappy**	**__Relaxed**
__Hopeless	**__Panicky**	**__Lonely**	**__Annoyed**	**__Nervous**	**__Tired**	**__Happy**

THOUGHTS:
These are things that you believe they think about.

__I am a special person
__I am popular
__I look good
__I cannot think clearly
__People do not like me
__I think people pick on me
__I am not very smart
__I like myself

__I think life is not really worth living
__I am bad, crazy
__I think others would be better off if I was dead
__I think the devil wants me to do something bad
__I am getting messages over the radio
__I think I am ugly, unattractive
__Life is really not worth living I can hear
__I think God speaks to me in a voice only

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD?

_____
_____
_____
_____
_____

Patient Name: _____ DOB: _____

Parent / Guardian Signature: _____ Date: _____

Emerald Isle Counseling LLC

Statement of Patient Financial Responsibility

Patient Name:_____**DOB:** _____

Emerald Isle Counseling appreciates the confidence you have shown in choosing us to provide for your mental health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Fee Schedule

			Average Session Timing
90791	Therapy Intake	195.00	53 min
90837	Ind. Counseling	145.00	53 min
90834	Ind. Counseling	135.00	45 min
90847	Family Counseling	145.00	53 min
Telephone/Skype Sessions		145.00	53 min

(Please call office for any additional quotes)

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

We accept cash, checks or charge cards (plus a processing fee of 3%) as payment.
Any returned checks will have a NSF fee of $35 per check and the full account balance plus any NSF fees will be due for payment in full immediately.

Unpaid balances with be charged 1 1/2 % Finance Charge added monthly after 30 days which is an annual Percentage Rate of 18%. Balances over 90 days owed will be turned over to a collection agency and will be patient's responsibility to resolve payment directly with the agency.

I have read the above policy regarding my financial responsibility to Emerald Isle Counseling LLC, for providing mental health services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Emerald Isle Counseling LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature_____Date _____

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Emerald Isle Counseling LLC

Consent for Treatment and Authorization to Release Information

I hereby authorize Emerald Isle Counseling LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Emerald Isle Counseling LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature_____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call and cancel 24 hours prior to your appointment. Failure to do so may result in a $50.00 No Show fee.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Emerald Isle Counseling LLC will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature_____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered. I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature_____ Date _____

CHARGE CARD REQUIRED INFORMATION

Circle One: MASTERCARD VISA DISCOVERY

Name As It Appears on Credit Card: _____

Credit Card Account Number: _____

Credit Card Billing Zip Code: _____

Expiration Month/Day/Year: _____

Three Digit Security Code: _____

Cardholder Signature: _____

Card Information will be kept in patient's secured file.

EIC has my permission to charge my credit card for any services that have not been paid by myself or my insurance carrier, if applicable, including "no show" fee of $50 for missed appointments. Charge Cards payments require a 3% processing fee and will be added to the balance owed.

Patient/Guarantor Signature: _____ **Date:** _____

Notes:

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Emerald Isle Counseling LLC

I,_____DOB_____

Authorize _____

To Release the following information from my medical, psychiatric and substance abuse records (if applicable):

__discharge summary
__psychiatric evaluation
__medical history/physical
__consultations
__lab reports
__correspondence
__ psychological testing
__neurological testing
__diagnoses
__biosocial history and assessments
__progress notes
__legal documentation

_x__ Check here to authorize all of the above: ___initial

To be sent to: Billing Office Emerald Isle Counseling
302 Magnolia Street
St Simons Island Ga 31522
912-268-4750 Office 888-837-0039 Fax

For the purpose of: Continuity of Care and Transference of Records

Information released is not to be further disclosed or used for any other purpose than that stated in this authorization. It is understood that I have the right to revoke this consent in writing. I have the right to inspect and copy the information released.

This authorization is valid until_____.
Expires one year from date signed unless otherwise indicated.

Patient's Signature:_____Date_____

Parent Signature:_____Date_____

CLIENT RIGHTS

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home? (circle one) YES NO. May we contact you at work? YES NO. May we contact you by cell phone? YES NO. Where may we contact you? _____

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment or health care operational purposes or that we shared with you or your family or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

Patient/Guarantor Signature_____ Date_____

HIPAA 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 INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: Today's Date (see below)

Emerald Isle Counseling, Inc., has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Georgia State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Patient /Guarantor Signature_____ Date_____

Emerald Isles Counseling LLC

FINANCIAL INFORMATION ADDENDUM

FEES INCURRED FOR LEGAL AND COURT SERVICES

Preparation time (including submission of records): 125.00 per hour Phone calls: 125.00 per hour

Depositions: 175.00 per hour

Time required in giving testimony: 175.00 per hour

Mileage: $0.55 per mile

Time away from office due to depositions or testimony: 175.00 per hour

All attorney fees and costs incurred by the therapist as a result of the legal action.

Filing a document with the court: $100

The minimum charge for a court appearance: 750.00 ½ day minimum 1500.00 full day

Compliance and program completion documentation 100.00