Creative Solutions Counseling LLC

Individual / Couple / Family

INTAKE INFORMATION

DEMOGRAPHIC INFORMATION

Patient's Name: ______________________ DOB: __________

Address ______________________ MD
Street City State Zip Code

Phones: __________ __________ __________
HOME CELL WORK

Email: __________ Email: __________

Social Secuirty # __________

Marital Staus: (Check One) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PATIENT
Occupation: __________
Company / School:

PARTNER / PARENT / GUARDIAN
Occupation: __________
School / Company:

Who do you live with: ☐ Family ☐ Friends ☐ Alone ☐ Other

	NAME	DOB	RELATIONSHIP	Will he/she attend therapy session?
1				☐ Yes ☐ No
2				☐ Yes ☐ No
3				☐ Yes ☐ No
4				☐ Yes ☐ No
5				☐ Yes ☐ No

INSURANCE INFORMATION

PRIMARY INSURANCE

Select Insurance Provider: ☐ CIGNA ☐ Blue Cross/BlueShield ☐ Medicaid ☐ Other __________

Name of Insured: __________ Card Nº: __________ Co-Pay: $ __________

SECONDARY INSURANCE

Select Insurance Provider: ☐ CIGNA ☐ Blue Cross/BlueShield ☐ Medicaid ☐ Other __________

Name of Insured: __________ Card Nº: __________ Co-Pay: $ __________

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Creative Solutions Counseling LLC
Financial Agreement:

I have discussed the following types of financial payment plans and procedures with my therapist, Cynthia Rebholz.

PAYMENT PLAN- Please check A or B

______Plan A (Private Pay)

I agree to pay $________per session. Payment is expected at each session, unless I have made prior arrangements with my therapist.
Date: __________ Signature: ____________________________

_____Plan B (Insurance)

Primary Insurance____________________________________

Phone #__________________________

Policy/ID#____

Policy Holder________________________________DOB:______________

Employer Name____

Social Security Number____

Our office is pleased to file for your insurance benefit or assist you with reimbursement. After verification of coverage, we will assist you in every way we can. However, it must be fully understood that the contract is between “You” and your insurance company and you are fully responsible for any amount not paid by your insurance company.
Our office does not guarantee that your insurance company will pay. We will attempt to verify your insurance coverage. However, if your insurance claim is denied, you are responsible for the full amount of the bill. We will not enter into a dispute with your insurance company over your claim. That is your responsibility and obligation.

I hereby authorize Cynthia Rebholz, LCMFT to apply for benefits on my behalf for covered services rendered by this office. I request that payments from my insurance be made directly to Cynthia Rebholz. Should an insurance payment inadvertly be sent to me, I would endorse it and return it to Cynthia Rebholz immediately.

I understand that I am financially responsible for any unpaid balance by the insurance company within sixty (60) days of the date of service. I certify that the information I have reported with regard to my insurance is accurate

POLICY REGARDING REPORT WRITING AND CONSULTATIONS
If you request your therapist to write reports, you will be billed $40.00 PER DOCUMENT. This may include brief letters/reports. However, please request that your therapist write any needed letters at the beginning of your session, so your session can include information about your request to write your letter.

Finally, if you need your therapist to consult with teachers, principals, other doctors, social workers, attorneys and/or any other professionals, we are happy to provide this service. However, you will be billed for your therapist's time according to their hourly fee and the amount of time needed for the consultation. Again, this does not include brief phone calls. Any report or phone call that takes 10 minutes or more will be billed to you.

CANCELLATION/RETURNED CHECK POLICY
I understand that appointments not cancelled 24 hours in advance may be charged A fee of $35.00 /per session and must be paid at the next session. I understand that a $15 service charge will be added to all returned checks.

I understand and agree with all of the above (page 1 and 2). Please sign your name below.

Date: ________________ Signature: ___________________________

Therapy Agreement and Privacy Policies (HIPPA)

Creative Solutions Counseling LLC
Cynthia Rebholz, LCMFT

Welcome to Creative Solutions Counseling. You have made a decision to begin a therapy, which may be beneficial to your goals and relationships. My therapeutic approach is to collaborate with clients, which means your participation is crucial. Initial sessions will include an assessment of your unique situation and needs. You may have questions or concerns along the way; please express yourself that I may better provide for your clinical care.

Sessions: are 45 to 50 minutes long unless an extended session is requested. Kindly give 24 hours notice if you need to cancel a session. Failure to cancel an appointment may result in a $35.00 missed appointment fee. Insurance does not cover fees for missed appointments.

Contact and Service Coverage: Please call to schedule or change an appointment. I may not be available to take your call immediately, so please leave a voicemail. I make every effort to return calls within 24 hours. If at any time you need immediate non-life threatening assistance please call the crisis center at 240-777-4000, or if you feel suicidal or experience a potentially life threatening emergency call 911 or go to the nearest hospital emergency room.

Client Confidentiality and Privacy: Your privacy is important; the law provides protection of communications between a client and therapist with some exceptions. Information and records concerning a patient may be disclosed for several reasons, including law enforcement requests required by local, state, or national law enforcement. Further, if you disclose any information about past or present child abuse involving yourself, or someone else, you understand that your therapist is legally obligated to report the information to Child Protective Services. If you disclose information that threatens safety or harm to self or other, your therapist is legally and ethically obligated to contact any appropriate persons and agencies and confidentiality may be compromised. Generally, Cynthia Rebholz obtains a written authorization from the patient before releasing information to third parties for purposes other than treatment payment, and health care operations, unless disclosure is required by law or permitted by law.

Privacy and Exceptions:

1. Cynthia Rebholz may use or disclose your protected health information to provide for your treatment, obtain payment for treatment, or perform health care operations.
2. If an adverse party subpoenas mental health records, I will assert the psychotherapist-patient privilege on behalf of the patient and will thereafter act according to the wishes of the patient and the patient's attorney, unless I am ordered by a court or other lawful authority to release records or portions thereof. (Court Order, Subpoena and Maryland agencies of public health, for investigation of privacy, audit, criminal or civil investigation).
3. I keep patient records, in a locked file for the mandated time period. When records are destroyed; they will be destroyed in a manner that protects privacy and confidentiality.
4. As a therapist, I am mandated and obligated to report suspected child abuse. I am also compelled and permitted to report situations that include mental or emotional states that I deem make you a danger to self or others, or you indicate a clear threat of harm to self, property or the person of others; this includes verbal threats of violence and behavior.
5. Client authorizes Cynthia Rebholz to discuss case/services as required by **health insurance carrier.** Please note therapist is not responsible for any breach of confidentiality by **health insurance carrier** or **Electronic billing clearing-house** (EDI claims).

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6. Occasionally, I may consult with another health or mental provider regarding your case. I will advise you, if I do consult with another provider, unless I deem that disclosure would adversely affect you. All providers are legally bound to protect your privacy.
7. This list is not exhaustive, but defines most instances when your protected health information may be disclosed. To protect your privacy, I am obligated not to release therapeutic notes to any person or agency without your written consent. In fact, I will only release therapeutic notes, if subpoenaed by a court of law. And, if the notes are subpoenaed, I will request to provide only a written summation of the notes to the court.
8. Personal relationships with your therapist are never appropriate. I will not approach you in public, to keep your privacy. Only if you acknowledge your therapist, by initiating a smile, wave or conversation, will your therapist will respond accordingly.

Therapy Information:

1. I understand if I come to a session under the influence of alcohol or drugs my therapist may elect to reschedule my appointment.
2. I agree to contact my therapist by phone (not by email) If I need to change an appointment.
3. I understand if my therapist needs to terminate services, she will provide me with two weeks notice and provide three resources if I decide to seek treatment elsewhere.

Email/Social Media: If you choose to email clinical information to your therapist, you understand that due to the nature of the Internet, confidentiality is never guaranteed. Email is also subject to becoming part of your clinical record. Therefore, do not send third party emails. Encrypted email is offered via Therapy appointment (therapyappointment.com). I do not friend clients on social media. However, if you view social media, blogs, articles and information created by Cynthia Rebholz on the Internet, please do so as member of the general public. You need to consider any risk of commenting, or identifying yourself as a current or past client. Please remember that articles and blogs are not clinical services.

Minors: Clients under age 18 years of age and not emancipated need to have a custodial parent sign consent for therapy. **Termination:** A client may terminate services at any time in session or by phone. Generally therapy ends when the client and therapist believe that services are no longer needed. **Agreement:** I (We) have read the above conditions and agree to them.

Client Signature___________________________ Date ____________________________

Partner Signature_________________________ Date_________________________

Minor(s): Name of Child/Children____

Signature legal guardian(s) ____ Date__________

Creative Solutions Counseling

Registration and Encrypted Email Instructions

To log into your account, please go to therapyappointment.com

Click on find your therapist (type in Cynthia Rebholz).

Please note online scheduling is not available. Please call Cynthia Rebholz to schedule.

Your login consists of your user name (first name) and password (last name).

1. Complete the registration page.

   *Section 1. Enter your demographic information.

   Section 2. You may change your login user name and password. Log into your account to send encrypted email to your therapist. (Remember if you opt to use unencrypted email your private health information is not guaranteed to be confidential).

   Section 3. Complete the insurance information. This does not mean your insurance will be accepted, but will be used for reimbursement and flex-spending receipts. Remember all parties in therapy must be on the same policy to be covered.

   Section 4. Include a brief statement describing the reason for the appointment.

2. *Submit information after complete the biography page.

If you have questions regarding confidential registration or encrypted email contact Cynthia Rebholz at 240-230-7182

Thank you for completing the online information!