Anchor of Hope, LLC: Policies & Fees

Welcome: Please read all information below before signing. It's important that you understand the information contained in this document. Please ask questions if need be.

Consent to Treatment: Cognitive Behavioral, Behavioral, Supportive, Solution Focused and feedback, etc …therapies are used to assist the patient in understanding "self" on a deeper level and gain insight to make changes. There is **NO quick fix**.

Agreement for payment: In consideration of rendering therapeutic services at Anchor of Hope LLC the undersigned (whether signing as the patients, or as parent, legal guardian, spouse, or representative of the patient) do hereby agree and guarantee payment in full of any and all charges for service rendered to or for the patients of Anchor of Hope LLC.

Records: All patients' notes are held according to HIPAA guidelines. Anchor of Hope will NOT be used for divorce and or child custody issues, so **Please DO NOT subpoena me and the notes to court.** My FEE in this event is $250 per hour plus I need 21 day notice to prepare my present patients. Payment is due 48 hours in advance and is NON-Refundable.

Assignment of Insurance Benefits:In consideration for rendering of services by Anchor of Hope LLC, the undersigned do hereby assign benefits of any type arising out of any policy of insurance insuring the patient or other party liable to patient which covers treatment directly to Anchor of Hope LLC. Members of Health Maintenance Organizations and preferred provider organizations are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements, preauthorizations, precertifications , etc… These are conditions to payment of Anchor of Hope LLC, charges rendering in any case in which payment may be denied by the health maintenance organization or preferred provider organization, because of a failure or comply with such coverage requirements or for any other reason.

Appointments: Please call 636-388-2129 for appointments. To cancel/reschedule please call at least 24 hours in advance. **There will be a $40 charge for clients not showing up for appointments or making a cancellation with less than 24 hours notice,** unless you reschedule your appointment during the same week. If you are 10 minutes late for your appointment, please call to reschedule your appointment.

Please refrain from using cell phones and online devices during appointments.

Anchor of Hope, LLC

Kelly L. Roberts, MED, LPC

37 St. Andrews Dr., Union, MO

INITIAL INTAKE

Date: _______________

Client's name: ____Date of birth: _______________

Legal Guardian (for minor client) ____

Address: ________________________________ City/Zip: ________________________________

Phone number:(C)_____________________________Email _______________________________

Can I send a reminder text for appointment? Yes No Marital Status M S W D

Primary Language:______________________________ Sex: M F

Employer/School: _____________________________________Occupation__________________

Name of insured: _____________________________ Insured's date of birth: ________________

Primary Insurance Company and ID #____

Secondary Insurance Company and ID#____

Name and phone number of primary Doctor: ____

Current Medications and Dosages:____

____

Emergency Contact____Phone(____)______________

Medical and/or Psychiatric Diagnosis:____

What brings you here today: ____

____

Referral Source:____

I have filled out and read both pages and understand the risk and hereby give my consent (consent to minor) for treatment and services provided by Anchor of Hope LLC. I also received a Notice of Privacy Practices and agree to the terms as stated.

Date__________________Signed____

Please print out forms and bring them filled out to first appointment.
Please call me at 636-388-2129 if you need to change/cancel your appointment.

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 IT CAREFULLY.

I will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"). I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoked in writing as provided in the Privacy Regulations. I am permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment, and health care operations. For example, protected health information may be disclosed from one staff member to another for consultation.

Subject to requirements of the Privacy Regulations, I may use and disclose protected health information for purposes of complying with legal requirements, public health activities, reporting abuse, neglect, and domestic violence, cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations; for judicial and administrative procedures; for law enforcement; with respect to descendents; with respect to serious threats to health or safety; specialized government functions; and incident to use or disclosure otherwise permitted or required by the Privacy Regulations, as provided under the Privacy Regulations. I may also disclose protected health information, pursuant to your agreement, to persons indicated by you for involvement in your health care and for notification purposes.

Missouri State laws with respect to genetic information and to human immunodeficiency virus infection status are more stringent than the Privacy Regulations, and protected health information regarding these matters will be disclosed only in accordance with governing Missouri statutes.

You have certain rights with regard to the handling of your protected health information, as provided in the Privacy Regulations. These are as follows: You may request restrictions on certain uses and disclosures of protected health information, however, I am not required to agree to a requested restriction. You may receive confidential communications of protected health information as provided by the Privacy Regulations. You may inspect and copy your protected health information, pursuant to a written request, subject to certain restrictions in the Privacy Regulations, such as a restriction on access to psychotherapy notes. You have the right to appeal a denial of access to your records. You may request an amendment of protected health information and demographic information, pursuant to a written request, subject to certain limitations in the Privacy Regulations. You have the right to contest a denial of an amendment. You may receive an accounting of certain disclosures of protected health information. You may obtain a paper copy of this notice upon request.

You may complain to me and to the secretary of Health and Human Services if you believe your privacy rights have been violated. If you wish to contact me for further information, or to complain, you may do so at 636-388-2129. I will not take any action against you for filing a complaint or for exercising your rights under the Privacy Regulations.