**Pine Ridge**
**Pastoral Counseling Services**
7913 East Ridge Pointe Drive Fayetteville NY 13066

Rev. Michael Heath, LMHC, Fellow AAPC

Phone/Text: 315 380 1005 Fax: 315 637 0605 E-mail : mheath1@twcny.rr.com

# CLIENT INFORMATION SHEET

_____

Date: _____
Name: _____
SS#: _____
DOB: _____
Address _____
_____
_____

Phone- Home _____ Mobile _____
E-Mail address: _____

Primary concerns and reasons for seeking treatment _____
_____
_____

Current Medications _____
Primary Care Physician - _____
Phone # _____
Fax # _____

Prior psychotherapeutic treatment _____
If yes, approximate dates.
Insurance Carrier _____
Phone # _____
Address _____
Policy type _____
ID # _____

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Text: 315 380 1005
7913 East Ridge Pointe Drive Fayetteville NY 13066 Website: www.revmichaelheath.com

## Privacy and Security Practices Statement

In accordance with the new federal guidelines for ensuring patient confidentiality and information safety, the HIPAA law requires that a summary of our privacy and security practices be explained and provided to you.

Your signature here indicates that you have received an explanation and that a copy of the practices has been made available to you.

This authorization expires as of: / /

Client Name: _____Date _____

Witness: _____Date _____

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | NPI | |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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# Pine Ridge Pastoral Counseling Tele-Therapy Policies and Signed Consent for Treatment Form

Here are some basic rules to help avoid any confusion about what is expected from you while you are in treatment with Rev. Heath:

**1. Fees and Payment**
-- Fees are normally established at the first appointment, for which there is also a charge.
-- Payment is expected for each session or by special arrangement via Zelle, Venmo or personal check.
-- If you are paying by check, the check should be filled out prior to the appointment to either Michael Heath or Pine Ridge Pastoral Counseling.
-- If you have difficulty paying for a session, please discuss your concerns with Rev. Heath. He will be glad to explore special payment options with you.

**2. Appointments, Cancelations and Broken Appointments**
-- Sessions are normally by appointments which have been made in advance.
-- 24 hour prior notification is needed to avoid being charged for a scheduled session, exceptions may be discussed with Rev. Heath.

**3. Use of Insurance**
-- Health insurance may be used for part or all payment, depending on the particulars of your policy.
-- Verification of your plan benefits must be obtained in writing.
-- Details concerning necessary Pre-authorizations, Deductibles and other referral requirements are the client's responsibility and need to be obtained and verified before insurance can be accepted for payment. Until then, the client is responsible for payment.
-- It is the responsibility of the client to stay informed regarding the extent of coverage, the number of sessions authorized and when further authorization is needed for additional visits throughout the course of treatment.

**4. HIPAA compliance**
As is indicated by the HIPAA statement, Pine Ridge is in full compliance with the HIPAA laws.

**5. Emergency Contacts outside of appointments**
-- Sometimes, especially at the beginning of treatment, it may be necessary to contact Rev. Heath by phone or e-mail. This is normal and no problem. In emergencies, however, the client must call 911. Since it is sometimes difficult to reach Rev. Heath, time must not be wasted trying to reach him.
-- It should be noted that the e-mail format is not secure and is not appropriate for personal or detailed information that a client does not want exposed.

If you have questions, please feel free to discuss them with Rev. Heath.

I agree to participate in counseling with Rev. Heath. I have read, understand and agree to comply with these policies. I also understand that I may withdraw from counseling at any time.

Name: _____
Signature _____
Witness _____

(revised 4 21 2022)

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# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client: _____

DOB: ; SS#

consents to the release of information: (phone consultations and written reports)

Between: Rev. Michael Heath, LMHC, Fellow AAPC
and :

Phone
Fax

Extent of information: All relevant information pertaining to clients diagnosis treatment and progress.

Purpose / Need for information: Coordination of Treatment

Expiration date of Authorization: / /20

I hereby authorize the release and exchange of designated information by the above named parties for the stated purposes.

Signature:_____ Date_____

Witness : _____Date_____

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GOOD FAITH ESTIMATE FOR PSYCHOTHERAPEUTIC SERVICES**

This form is required to be in full compliance with the **No Surprises Act** passed by Congress. Its purpose is to provide a realistic estimate of the cost of your counseling so that there will be no confusion about the charges made to your account.

1. Name:
   DOB:

2. Service provided : Outpatient psychotherapy and/or pastoral counseling.

3. DX: Z71.1

4. Provider : Rev. Michael Heath LMHC, Fellow AAPC
   TIN: 76-0809717
   NPI: 1295943379

5. Out of Pocket Fees: The fee for a 45 minute session ranges from $100.00 to $200.00 depending on the client's ability to pay, which will be determined by the therapist in the first session. Based on the information that you have provided, your per session charge will be _____.

   From time to time, fees for additional services such as emergency contacts, written reports or pertinent consultations with other professionals involved with client's situation may be incurred. The fee for these extra services will be discussed separately at the time they are recommended.

6. In the case of a balance dispute, the client has the right to initiate a client-provider resolution process.

7. This estimate is **not a contract .** It is an statement of the cost of therapy based on a per session basis. Your signature is simply to indicate that you understand and accept the fees. Since everyone's situation is unique, a precise number of sessions needed or the total cost of treatment cannot be determined in advance. It can be stated that, after twelve sessions, the progress made and whether further sessions are needed will be openly evaluated by the client and therapist.

Signed : Date:

Witnessed: Date

** Form only required for clients who pay out of pocket and who do not use insurance. 1/02/2022