Notice of Information Practices and Privacy Statement

For the Marblehead Counseling Center
66 Clifton Avenue Marblehead MA 01945

How We Collect Information about You: The Marblehead Counseling Center (The Center) and its employees and volunteers collect data through a variety of means including but not necessarily limited to forms, letters, phone calls, emails, voice mails. Information is also collected from the applications that are either required by law or necessary to process requests for assistance through our organization.

What We Do Not Do with Your Information: Information about your financial situation, mental health status and/or care that you provide to us in person, writing, email, telephone (including information left on voice mails), contained in or attached to applications, or directly or indirectly, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about clients who apply for or receive any services, that is restricted by law, or has been specifically restricted in writing by a client.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with counseling services or process an application for assistance. Typically, the information is used for communication between The Center and health insurance companies to verify and bill your health insurance. We are legally obliged to tell you that if you apply to receive a reduced fee and provide information with the intent or purpose of fraud including willful or unwillful acts of negligence, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: Unless you submit data directly to us via the website, we do not collect any other information about your visit. We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.marbleheadcounseling.org) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site.

Limited Right to Use Non-Identifying Personal Information: Any pictures, stories, letters, cards, correspondence, or notes sent to us become the exclusive property of The Center. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that no information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

By signing below, I am indicating that I have received and read The Center's Notice of Privacy Practices as required by law.

_____ _____

Client Signature **Date**

Marblehead Counseling Center
Guide.Heal.Grow.

Client Intake Packet **CONFIDENTIAL**

Payment Policies and Client Financial Agreement

Client Name: _____ Client #:_____ Therapist : _____

IMPORTANT: All co-pays and fees are due at time of visit. If two appointments are unpaid, no further appointments will be scheduled until the balance is paid in full or a payment plan is approved.

If you have insurance coverage

- Co-pays are due on each day of service, as required by your insurance company. Insurance payments are processed on a contracted fee schedule. You are responsible for co-payments, deductibles and any other client-responsible fees in effect at the time of each appointment.
- It is your responsibility to obtain authorizations and know your insurance benefits
- We will take a copy of your insurance card at your first visit. You must notify us immediately if your insurance changes or be responsible for uncovered visits.
- If your insurance company notifies us that this co-pay has changed or is incorrect, you are responsible for any additional fees.

If you are a self-pay client (and no insurance will be used to pay for your sessions)

- It is your responsibility to pay all fees at the time of service unless previous arrangements have been made. If you would like to request a sliding-scale fee, please request an Application for Reduced Fee from our receptionist or your therapist. Only Marblehead residents are eligible for a reduced fee.

Appointment Cancellation Policy

- If you cancel an appointment without 24 business hours notice, or fail to show up for a scheduled appointment, you will be responsible for a $25 fee. (MBHP clients are not subject to this fee.) If you reschedule within the same week, this fee may be waived. Exceptions will be made only for emergencies.
- If you miss two appointments in a row or frequently cancel, you may forfeit your regularly scheduled appointment time. Your therapist will discuss this with you.

The Center accepts cash, check and some selected credit cards.

I have read and understand these financial policies of The Center, and agree to honor them.

Signature (If under 18, have parent/guardian sign) Date

Please print signee's name if different from client: _____

Acknowledgement of Receipt of Information

Client Name: _____ Client #: : _____

We would like you to know about a number of issues and information regarding your clinical care. These issues are contained in the Client Handbook that you receive at your first visit to the Center. We encourage you to review the content of our Handbook. Some of these issues include:

- ✓ The way we safeguard your confidentiality, including our conversations in counseling sessions and written records or correspondence about your case
- ✓ Your responsibilities in the counseling process;
- ✓ The reasons for which we could terminate your treatment;
- ✓ How to file a grievance.

By signing below, I acknowledge receipt of the Client Handbook. This form will be kept in my clinical record.

Signature (If under 18, have parent/guardian sign) Date

Marblehead Counseling Center
Guide.Heal.Grow.

Client Intake Packet

CONFIDENTIAL

MCC Use Only:

[ ]New Client [ ] Change of Client Info Eff.: _____	Client#_____ Therapist _____ ICD-9 _____

Client Name _____ Today's Date _____

Address _____ Town _____

State _____ Zip _____ Preferred Phone _____ Home/Work/Mobile (*circle one*)

Secondary Phone _____ H/W/M Alt. Phone _____ H/W/M

DOB: _____ Gender: [ ]Male [ ]Female Marital Status [ ]S [ ]M [ ]D [ ]W

Emergency Contact Name _____ Relationship _____

Emergency contact Primary Phone _____ H/W/M Secondary Phone _____ H/W/M

HAVE YOU SEEN ANY MENTAL HEALTH PROVIDER IN THIS CALENDAR YEAR? [ ]YES [ ]NO #TIMES _____

HAVE YOU EVER RECEIVED SERVICES FROM THE CENTER? [ ]YES [ ]NO THERAPIST: _____

HOW DID YOU HEAR OF THE CENTER?_____

Please bill to [ ]Self [ ]Insurance [ ]Other *If Other, fill out information below.*

Name: _____Relationship to you _____

Address _____ Town _____

State _____ Zip _____ Primary Phone _____Home/Work/Mobile (*circle one*

1. Primary Insurance Company _____ Insurance ID # _____

Subscriber's Name _____ Subscriber's DOB _____

Subscriber's Relationship to you _____ Subscriber's employer _____

Authorization # _____ # of sessions approved _____ as of _____

Co-Pay $ _____

2. Secondary Insurance Company _____ Insurance ID # _____

Authorization # _____ # of sessions approved _____ as of _____

If you desire MCC to bill you or your insurance company for counseling services, please sign the following:

Release, Assignment and Responsibility

I authorize release of information which is necessary to process my insurance claim and request payment directly to the Marblehead Counseling Center. I also accept responsibility for any charges that my insurance company does not pay.

Signature (If under 18, have parent/guardian sign) Date

HBS _____