Phone:
(803)-569-3101
www.hillcrestcps.co

Annual Registration Update Form

Today's Date: _____

Full Name: _____

Date of Birth: ____/_____/_____ SSN*: _____/_____/_____ *required for insurance billing

Address: _____

City: _____ State: _____ Zip Code: _____

Primary phone number: _____ Email: _____

May we leave message: Would you like text message reminders?

Marital Status: Employment Status:

Company Name: _____ Phone number: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone number: _____

Insurance Information update

Policy Holder Information* SSN*: _____/_____/_____

Last Name: _____ First Name: _____

Date of Birth: ___/ ____ / _____ Primary phone number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance: _____

ID number: _____ Group ID number: _____

Secondary Insurance: _____

ID number: _____ Group ID number: _____

Self-Pay:

HILLCREST
COMPREHENSIVE
PSYCHOLOGICAL SERVICES

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Credit Card Payment Authorization

Hillcrest CPS is committed to providing you with exceptional care, as well as maintaining a simple and efficient billing process. To provide a seamless, convenient way for patients to pay their bills, Hillcrest CPS requires all keep an active card on file with us.

By signing this form, you give Hillcrest CPS permission to charge your card for the amount required for: **self-pay, copays, missed appointments, late cancellations and/or deductibles at the time of sessions.** An active credit or debit card must be on file or a $99.00 cash deposit will be necessary to see a clinician. If you have any question about payment method, please contact the front office.

I, _____, authorize Hillcrest CPS to charge my debit/credit card account for any deductibles or copays that may apply at time(s) of service, including a $99.00 fee for missed appointments. * Be sure to cancel appointments 24 hours in advance to avoid fees. *

Cardholder Information

Name (as it appears on the card): _____

Billing address: _____

City: _____ State: _____ Zip code: _____

Primary Phone Number: _____ Email: _____

Visa: _____ **Mastercard:** _____ **Discover:** _____ **Health flex card**: _____

Card number: _____- _____ -_____ -_____

Expiration date: _____ / _____ Security Code (back of card): _____

I authorize the Hillcrest CPS to charge the credit/debit card indicated in this authorization form according to the terms outlined above. Payment authorization is for the services described and valid for all sessions that require payments at the time of services. I certify that I am an authorized user on this debit/credit card. I will not dispute the payment with my debit/credit card company so long as the transactions correspond to the term indicated in this form.

Signature X: _____ Date: _____

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Patient Authorization to Disclose Protected Health Information (PHI) to a Third Party

Please contact us if you have any changes in this request. If you need a record to be released to a third party, this form must be signed and filled out.

Patient Information: Individual whose information may be disclosed.

Name: _____ Date of Birth: ____/____ / _____

I authorize Hillcrest CPS to disclose my protected health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Important Terms of PHI

I understand that if I have any questions about my clinical records or content within, I can contact Hillcrest CPS and someone will meet with me to discuss my records. I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 45CFR, PART 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that authorization is outgoing but that I may revoke this consent at any time and that any notice to revoke consent must be in writing. I understand that the information used or disclosed may be subjected to re-disclosure by the person, class of persons or facility it and would then no longer be protected by federal privacy regulations.

Signature X: _____ Date: _____

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___

- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Office Staff Date

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
11. I understand that different states have different regulations for the use of telehealth.

Payment for Telehealth Services

illcrest CPS , LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, our sliding scale rate is available. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____

Print Name

_____ _____

Client's Signature/ Date

_____ _____

Parent or Guardian Signature/ Date

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