LIFECARE MENTAL HEALTH SERVICES, LLC
Patient Intake

Please email forms to our office: admin@lifecarementalhealth.com

Client Information:

Last Name First Name Middle Initial
____

Home Address ____
City State Zip

Phone number(s) Social Security Number

____________________________ __________________________

DOB Emergency Contact Name/Phone Number

__________ ____

FOR MEDICAID RECIPIENTS:

Name of Insurance Company _____________________________

Member ID Number _______________________________

Medicaid ID Number (Can be found on the card with the horse logo) ___________________

ONLY COMPLETE IF INSURED THROUGH PARENT OR EMPLOYER:

Name and DOB of Policy Holder___________________________

Relationship to Client____________________________

Place of Employment____________________________

Name of Insurance Company____________________________

Member ID______________________ Group Number_____________________

Copay Amount________________Annual Deductible Amount_____________________
Comments: ____

Primary Care Communication Form

Please complete this form if you would like our office to inform your doctor that you are being treated by LifeCare Mental Health Care Services:

Today's Date:_____________

Patient Name: ______________________________DOB: ______________

Primary Care Office: ____

Phone number: ________________________Fax: _________________________

This letter is to inform my primary care doctor that I am receiving services at **LifeCare Mental Health Care Services** for:

____
Symptoms or Diagnosis

I plan to receive the following treatments while in the care of Kentucky Counseling Center:

____ Psychotherapy
____ Medication to reduce mental health symptoms
____ Both

I give LifeCare Mental Health Care Services and my PCP office, listed above, permission to share my private health information with each other. This consent does not expire until I submit a written request to terminate communication.

____
Patient Signature Date

____
Provider or Administrative Staff Signature Date

INFORMED CONSENT

By signing this form, you agree to receive mental health services provided by LifeCare Mental Health Services, LLC, and its independent contractors. We know that starting counseling is a big decision and you may have many questions. We will do our best to answer any questions or concerns. This form explains information about KCC policy, State and Federal
Laws, and your rights about counseling. All LCMHS employees and contractors have met the highest level of education, certification, and licensing requirements set forth by Kentucky state law. Counseling practices, philosophy and plan limitations and risks will be discussed with you today.

TREATMENT PROCESS AND DOCUMENTATION

It is the mental health professional's responsibility to keep accurate records including Evaluations, Treatment Plans, and Progress Notes. By signing this document, you are consenting to the Treatment Plan that your provider creates and agree to any goals, objectives, and therapy techniques that may be used in your therapy process.

INSURANCE BILLING

If you plan to use insurance to pay for services, claims will be sent to the insurance company based on information used at the time of service. Sometimes, insurance information may change or may not be up to date. If for any reason, inaccurate information related to deductibles, co-pays, or number of available sessions, etc. is retrieved at the time of service, LCMHS will bill the client for any additional costs associated with mental health services

rendered. Additional services may not be provided until the client's balance is current. If balances remain unpaid for 60 days, client information will be sent to a
collection agency.

MISSED APPOINTMENT FEES

Appointments will be canceled and the provider's full fee amount will be assessed if the client is 15 minutes late without notice. If client cancels an appointment without a notice greater than 24 hours, LCMHS will charge the client the provider's full fee.

CREDIT CARD PAYMENTS

You may choose to have LCMHS store your credit card information for future bills you may incur. Should you do so, LCMHS will automatically process all outstanding balances one time per month and will not provide any additional warning other than what is written in this section of the Informed Consent form.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Confidential information discussed in session is not discussed with anyone without your written permission except for:

1. Diagnosis and dates of service shared with your insurance company to process your claims
2. Information you tell LCMHS about physical, sexual or elder abuse; then, by Kentucky State Law, I have to report this to the Kentucky Department of Children and Family Services
3. Where you sign a release of information to have specific information shared
4. If you tell LCMHS you are in danger of harming yourself or others
5. Information shared with therapist's clinical supervisor if applicable
6. When required by law.

If you need to contact me between counseling sessions please call my office. E-mail, text messages and social networking sites are not confidential and I may not be able to respond. If an emergency situation would happen, you can call my office to have a counselor call you. If no call is received within 15 minutes or you can't wait, call 911.

______________________________ ____________________

Patient Signature Today's Date

HIPAA 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.

LifeCare Mental Health Services, LLC is committed to maintaining client confidentiality in accordance with federal and state laws and ethics of the counseling profession. This notice describes our policies related to the use and disclose of your healthcare information.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Your health information may be used for the purposes of providing treatment services, collecting payment, and conducting healthcare operations as necessary to support our operations and to promote quality care. We will use and disclose your information for these purposes as state and federal laws allow. Examples include:

Treatment We may need to use or disclose health information about you to provide, manage, or coordinate your care or related services, including with third parties such as consultants and potential referral sources.

Payment We may use and disclose your information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as for billing and collection purposes. We may bill the person in your family who pays for your insurance.
Healthcare Operations We may need to use information about you to review our treatment procedures and business activity. For example, information may be used for certification, compliance, and licensing activities. We may also contact you with information about treatment alternatives or other services that may be of interest to you. We may send you appointment reminders by text or by phone and/or leave a voicemail.

OTHER USES AND DISCLOSURES

Opportunity to Object to Certain Uses and Disclosures

You have the right to tell us whether you want us to use or disclose your information for the following purposes:

To Individuals Involved in Your Care or Payment for Your Care. We may share medical information about you with your family members, friends, or any others involved in your medical care or who helps pay for it. We may also share you information as necessary to identify, locate, and notify family members, guardians, or others involved in your care about your location, and general condition.
For Disaster Relief. In some cases, we may share limited information about you to a disaster relief agency assisting in disaster relief efforts.

If you are not present or unable to tell us your preference, we may go ahead and share your information if your health care provider thinks that it may be best for you.

Other Permitted Uses and Disclosures

We may share your information when needed to lessen a serious and imminent threat to health or safety. When permitted by law, we may also share information in certain situations to help with public health and safety issues. For example, in preventing disease, reporting adverse medication reactions, or helping with product recalls. We may share information with a medical examiner or coroner when an individual dies. We may share information with health oversight agencies for activities authorized by law, and for certain specialized government functions such a national security and presidential protective services.

Required Uses and Disclosures

There are some instances where we may be required by law to use and disclose information. For example, when you and/or your child or children report information about physical or sexual abuse, when required by the Secretary of the Department of Health and Human Services to audit or evaluate our compliance with the requirements of federal privacy law, or if you provide information that informs us that you are in danger of harming yourself or others. We may share information with law enforcement consistent with applicable laws, such as if a crime is committed on our premises or against our staff, or if required in response to a valid court order.

Use and Disclosure Requiring Your Authorization

Certain uses and sharing of your health information are only permitted with your written authorization. These include most uses and disclosures of psychotherapy notes, uses and disclosures of your health information for marketing communications, and disclosures that constitute a sale of your health information.

Uses and disclosures of your health information other than those described in this notice will be made only with your written authorization.

You may revoke an authorization, at any time, in writing, except to the extent that your provider or we have taken an action in reliance on the use or disclosure indicated in the authorization. To revoke an authorization,

you must write to LifeCare Mental Health Services, LLC at the address listed below.

CLIENT RIGHTS

The following is a statement of your rights with respect to your protected health information. If you have questions about how to exercise these rights, contact our Privacy Officer using the information below.

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders. Sometimes we may send a text appointment reminder or leave messages on your voicemail. You have the right to request that our office communicate with you by alternative means or at an alternative location. You must submit your request in writing to us at the address below. We will agree to reasonable requests.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke your consent, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such consent.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the Privacy Officer. Under limited circumstance we may deny your request to inspect and copy. When permitted by law, may charge a reasonable fee for the costs of copying, mailing, and supplies to provide a copy of your information.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the Privacy Officer. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of any cost involved in preparing this list. Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our Privacy Officer. You must tell us the type of restriction you want and to whom it applies. We are generally not required to agree to such a request, with one exception. You have a right to restrict any disclosure of personal health information for payment purposes or for our health care operations if you have paid for services out-of-pocket and in full.

Breach Notification.
You have a right to receive notification of a breach of your unsecured personal health information.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. You may also file a written complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing such a complaint.

OTHER INFORMATION ABOUT THIS NOTICE

Compliance with Laws
We are required by law to provide you with this notice of our legal duties and privacy practices with respect to your protected health information, and to notify you in writing if the privacy or security of your health information is breached. We are required to abide by the terms of our Notice of Privacy Practices currently in effect.

Right to Request a Paper Copy
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Revisions to This Notice
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have, as well as any we get in the future. Any changes in this notice will be posted on our website at lifecarementalhealthservices.com. The revised notice also will be available upon request.

Our Notice of Privacy Practices was originally effective in August, 2014.
This revised version is effective as of February 11, 2019.

Questions and Contact
If you have any questions about this notice or about how your health information is used or shared by us, please contact us at:
LifeCare Mental Health Services,, LLC
Attn: Privacy Officer
Address:
Louisville, KY 40213
Phone: 502-509-1342

Patient or Guardian Signature:____Date:__________

Mailing Address Louisville, KY 40218 | Phone: 502-509-1342| Web: lifecarementalhealth.com

Consent to Release Information

I consent for LifeCare Mental Health Services, LLC and those representing this group to share my private health care information with the following individuals and/or entities. LCMHS is permitted to send and receive information to and from the entities below if needed:

1. Representatives of Child's School (School Name)-______________________________
2. Primary Care Physician Name-_______________________________________
3. Emergency Contact Name-___________________________
4. Other/ Self-_______________________________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to **LifeCare Mental Health Services, LLC**. I understand that a revocation is not valid to the extent that **LifeCare Mental Health Services, LLC** has acted in reliance on such authorization. This authorization does not expire until I submit a written request. A copy of this release shall have the same force and effect as the original.

NOTICE TO RECEIVING PROVIDER OR ORGANIZATION: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for disclosure of this information by the recipient and, if that occurs, federal law may not protect the information.

____

Patient Signature (Parent/Guardian must sign if client is a minor) Date

____

Patient Signature Credentials Date