MIRACLE | Counseling

Initial verification completed by Office Personnel______________________________ on Date_____________

PATIENT CHART

DEMOGRAPHICS		
Name		Sex – ☐ F ☐ M ☐ Other
DOB:	Languages:	Relation to Patient
Home #	Cell #	Email:
Address:		

EMPLOYMENT						
☐ Full-Time	☐ Part-Time	☐ Student	☐ Unemployed	☐ Military	☐ Disabled	☐ Retired
Location:			Position:			
Phone Number:			Email:			

EDUCATION			
☐ Part Time	☐ Full Time	☐ Not Applicable	Institution
Level of Education:	Phone Number:	Email:	

EMERGENCY CONTACT #1		
Name:		Sex – ☐ F ☐ M ☐ Other
DOB:	Languages:	Relation to Patient
Home #:	Cell #:	Email:
Address:		

EMERGENCY CONTACT #2		
Name:		Sex – ☐ F ☐ M ☐ Other
DOB:	Languages:	Relation to Patient
Home #:	Cell #:	Email:
Address:		

ACTIVE MEDICATIONS (Use additional paper if needed)

Name of Medication	Quantity	Frequency

DISCONTINUED MEDICATIONS (Use additional paper if needed)

Name of Medication	Quantity	Frequency

ALLERGIES (Use additional paper if needed)

Allergy	Reaction	Protocol

This form was completed to the best of my knowledge and ability. It will remain my responsibility to update Miracle Counseling and Life Coaching LLC of any future changes.

Patient's Name Signature Date

Relationship to Patient Signature Date

8440 West national Ave. West Allis, WI 53227 | 414-405-1682 | www.miraclecounseling.org

INFORMED CONSENT

PROVIDERS	
Dr. Mirta Cabrera – LPC, PsyD	Dr. Lilian Tocco – MSEdu., MSLPC, PsyD
Abigail Webber – MS, LPC	Melissa Badertscher – MS, MSAT, LPC-IT

The Counseling Process
Counseling is summarized by guided methods of resolving issues with the assistance of a licensed professional. It is essential to establish a positive, professional, client-therapist relationship so that desired change can become the new lifestyle. Various therapy methods are used to promote long-term solutions unless there is an immediate need that should be discussed first. Typically, an initial biopsychosocial assessment is completed in the first session, followed by a treatment plan and mental health evaluations. Depending on the needs of the individual, the client could attend weekly, bi-weekly, or monthly appointments; there will be regular reevaluations of the efficiency of the treatment plan. Sessions usually last 30-60 minutes. Written reports may be provided if needed. Charges may apply. Clients have access to their charts and the objectives of their treatment.

Length of Service
A treatment plan will be determined after the client's initial assessment components. In the event that the client does not have insurance, the determined treatment plan will remain unchanged until a reevaluation takes place. Comparatively, clients with insurance may experience their HMOs to determine the length of service. In addition, the allotted span of service may not reflect the treatment plan. In that case, the client and therapist will seek the best possible plan for the client and plan according to HMOs coverage and make accommodations for self-pay. Referrals can also be provided. The therapist reserves the right to refer the client to a colleague or other mental health professional for further treatment or resources.

*****If the client has 3 missed appointments, there will be a 3-month hold on their appointments*****
Another reason for the interruption of services would be the client's inability to maintain scheduled appointments. There are competitive slots of time in which other clients also need aid in their day-to-day lives and require scheduled and timely assistance. If unable to attend, contact Miracle within 24 hours or become responsible for covering the session fee. In the event the therapist cannot keep an appointment, the receptionist will contact the client to reschedule.

Parameters
If a grievance should arise, the client is responsible for completing the Grievance Form (available at the front desk) in its entirety. Miracle will review the material and work on a resolution with the parties involved. An Authorization for Release of Information is required prior to information leaving the office and discussing confidentiality information with someone out of the therapeutic context. This consent relies on the confidential manner in which my case is discussed, and I understand it is solely dependent on providing me quality service. The client's services are based on the agreed treatment plan and Miracle Counseling and Life Coaching LLC's resources. If the therapist or client cannot meet the treatment plan's goals effectively, the therapist will refer the client to other resources. We work endlessly to provide a safe place for all beliefs, cultures, and races. Please note that Miracle Counseling and Life Coaching is LLC only open by appointment.

In case of an emergency, please call 911, contact the Suicide Prevention Lifeline at 1-800-273-TALK (8255), or go to the hospital most convenient near you. Otherwise, please make an appointment to directly discuss therapeutic matters with the therapist.

Cost
Copays, deductibles, and coverage depend on the client's health maintenance organization membership. In the event the client does not have coverage, a session-to-session payment plan will be established. Copies of the client chart are provided for a fee of $28. The price schedule is as follows:

THERAPY		
	30 MINUTES	**60 MINUTES**
Individual	$80	$140
Couples	$100	$180
Family	$160	$280

OTHER SERVICES	
Coaching (SET OF 2/4)	$250/$450
Courses	VARY
Letters	VARY
Reports	VARY

Confidentiality
I consent to the use of other agencies regarding payment of my therapeutic mental health sessions (if applicable). I also consent to share records with government agencies, health management organizations, and medical institutions for my well-being and their child's well-being (if applicable). All Conversations are strict confidentiality to the limits of the law. If the therapist believes that a third party, the therapist, or the client, is in danger, I consent to contact anyone responsible for the prevention of harm to occur. I also authorize the therapist to contact any medical or law enforcement personnel to aid in the manner of abusive, harmful, and life-threatening situations. The client authorizes the undersigning therapist to consult with the professionals relevant to promoting my well-being. Miracle Counseling and Life coaching LLC follows all of HIPAA's ethical standards prescribed by state and federal law. All guidelines promote the safekeeping of patient files, which include all written and recorded evidence provided by other professionals and institutions as well as collected during therapy. No information will be released without the patient's consent unless mandated by law. By consenting to the informed consent, you give the undersigned therapist permission to disclose information to persons required by law. In the event of a therapist's leave, the therapist's cases may be passed on to another therapist within Miracle Counseling and Life Coaching LLC. I agree to this process unless I arrange for a different approach.

Consent to Treatment
By signing below, I agree to have read the information provided and consent to receive mental health assessment, treatment, and services for myself (or child, if relevant). I also understand the parameters of counseling, my professional relationship with the counselor, and my own responsibilities. I am adherent to participation and am doing so on my own accord. In the event that participation is court mandated, I understand my rights and responsibilities as well. I know where to obtain help in the event of an emergency.

*****Good Faith Estimate is available upon request*****

I have read the informed consent and have understood my responsibilities and rights as a client.

Patient's Name Signature Date

Relationship to Patient Signature Date

Miracle Counseling has provided the informed consent and has explained mutual responsibilities and rights.

HIPAA INFORMED CONSENT

Background: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This is a "friendly" version. A more complete text is posted at the clinic. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. In addition, HIPAA provides certain rights and protects you as a patient. We balance these needs with our goals of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services www.hhs.gov.

Policies

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers, as is necessary and appropriate for your care.
2. Patient files are stored after sessions in locked filing cabinets. However, the normal course of providing care means that such records be left temporarily in administrative areas such as the front office, clinician's office, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
3. This practice aims to remind clients of their appointments. We may do so by phone, text, or email in the most convenient manner for you. However, it is not our responsibility to remind you of the appointments as this is a courtesy service we aim to render. In addition, we may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
4. The practice uses an off-site billing specialist that may have access to PHI but has agreed to abide by the confidentiality rules of HIPAA.
5. You understand and agree to inspect the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manage or your clinician.
7. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete, or modify any of these provisions to serve better the needs of both the practice and the patient.
10. You have the right to request restrictions in the use of your PHI and request change in certain policies used within the office concerning your PHI. However, we are not obliged to alter internal policies to conform to your request.
11. Surveillance cameras are present on the property for safety reasons and are being used to maintain the security and safety of staff and patients. Video footage from security cameras will not be used for evaluation purposes.
12. Both parties are prohibited from any type of recording (either voice or video) during sessions.

This form was completed to the best of my knowledge and ability. It will remain my responsibility to update Miracle Counseling and Life Coaching LLC of any future changes.

Patient's Name	Signature	Date
Relationship to Patient	Signature	Date

INSURANCE VERIFICATION FORM – CREDIT CARD PAYMENT

Patient's Name Date

PRIMARY INSURANCE INFORMATION			
Policy Holder's Name		Insurance Company Name	
Policy Holder's ID Number		Patient's ID Number	
Do you Work? – ☐ YES ☐ NO		Group Number	DOB
Company Name		Company Phone Number	
TYPE OF INSURANCE PLAN			
MEDICAID + HMOs			
☐ Medicaid Forward	☐ Molina Medicaid	☐ Anthem Medicaid	☐ UHC Community Plan
☐ NHP Medicaid	☐ MHS Medicaid	☐ iCare Medicaid	☐ Children's Community HP
COMMERCIAL			
☐ Humana	☐ UMR	☐ UHC EAP	☐ Molina Marketplace
☐ BCBS Commercial	☐ All Savers (UHC)	☐ Cigna	☐ United Choice One
☐ UHC Commercial	☐ Together W/ CCHP	☐ Beacon Health (EAP)	☐ Other

SECONDARY INSURANCE INFORMATION			
Policy Holder's Name		Insurance Company Name	
Policy Holder's ID Number		Patient's ID Number	
Do you Work? – ☐ YES ☐ NO		Group Number	DOB
Company Name		Company Phone Number	
TYPE OF INSURANCE PLAN			
MEDICAID + HMOs			
☐ Medicaid Forward	☐ Molina Medicaid	☐ Anthem Medicaid	☐ UHC Community Plan
☐ NHP Medicaid	☐ MHS Medicaid	☐ iCare Medicaid	☐ Children's Community HP
COMMERCIAL			
☐ Humana	☐ UMR	☐ UHC EAP	☐ Molina Marketplace
☐ BCBS Commercial	☐ All Savers (UHC)	☐ Cigna	☐ United Choice One
☐ UHC Commercial	☐ Together W/ CCHP	☐ Beacon Health (EAP)	☐ Other

NOT APPLICABLE

INCLUDE A COPY (FRONT & BACK) of INSURANCE CARD & IDENTIFICATION

*****Good Faith Estimate is available upon request*****

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CREDIT CARD PAYMENT – SELF PAYMENT

Patient's Name Date

INSURANCE WAIVER AND AGREEMENT TO SELF-PAY

I have selected not to use my insurance for my counseling sessions, and I understand that opting out of using my insurance means I must pay out of pocket for the counseling sessions.

Patient's Name_________________________ Patient's Signature_________________________ Date__________

PRIMARY – CREDIT CARD INFORMATION			SECONDARY – CEDIT CARD INFORMATION		
Cardholder Name			Cardholder Name		
Card Number			Card Number		
Expiration Date	(CVV)		Expiration Date	(CVV)	
Zip Code			Zip Code		
☐ Visa	☐ Discover	☐ Mastercard	☐ Visa	☐ Discover	☐ Mastercard
☐ American Express	☐ ATM	☐ Other	☐ American Express	☐ ATM	☐ Other

PRIMARY – ATM CARD INFORMATION			SECONDARY – ATM CARD INFORMATION		
Cardholder Name			Cardholder Name		
Card Number			Card Number		
Expiration Date	(CVV)		Expiration Date	(CVV)	
Zip Code			Zip Code		
☐ Visa	☐ Discover	☐ Mastercard	☐ Visa	☐ Discover	☐ Mastercard
☐ American Express	☐ ATM	☐ Other	☐ American Express	☐ ATM	☐ Other

NOT APPLICABLE ☐

INCLUDE A COPY (FRONT & BACK) of INSURANCE CARD & IDENTIFICATION

*****Good Faith Estimate is available upon request*****

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