Tenecia M. Bullock, LPC

Psychotherapist
Broader Spectrum Counseling, PLLC
2118 Oak Grove Rd. Suite A
Hattiesburg, MS 39402 (601) 499-5197
www.broaderspectrum@outlook.com

Intake Information

PATIENT'S NAME: _____
FIRST INITIAL LAST

PARENTS OF MINOR: _____

ADDRESS: _____CITY_____ STATE_____ ZIP_____

HOME PHONE: _____ PATIENT'S BIRTHDATE/AGE: _____

INSURANCE INFORMATION

PRIMARY INSURED'S NAME:_____

INSURED'S ADDRESS:_____

INSURED'S BIRTHDATE: _____ INSURANCE COMPANY _____

POLICY NO. _____ REFERRAL SOURCE:_____

CHIEF CONCERN

Please describe the main difficulty that has brought you to the clinic:

_____

_____

_____

_____

_____

PLEASE READ AND SIGN BELOW

INFORMED CONSENT

Thank you for choosing **Tenecia M. Bullock, LPC**. Today's appointment will take approximately 45-50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. **Tenecia M Bullock, LPC** has earned a Bachelor of Arts Degree in Psychology from the University of Southern Mississippi, and a Masters Of Science Degree in Mental Health Counseling from Capella University. Also, a Masters of Science Degree in Psychology was earned from Capella University.

I am licensed by the State of Mississippi as a Licensed Professional Counselor. I have over ten years of clinical experience in treating adolescents, adults and families using individual, family and group therapy. **Tenecia M Bullock, LPC** practices standard cognitive behavioral type therapies for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except* for: *a) information you and/or your child or children report about physical or sexual abuse; then, by Mississippi State Law, I am obligated to report this to the Mississippi Department of Human Services, b) if you provide information that informs me that you are in danger of harming yourself or others, c) where you sign a release of information to have specific information shared, d) information necessary for case supervision or consultation and e) when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact emergency services in the community (911) for those services and/or a local hospital emergency room.* ***Tenecia M Bullock, LPC*** *will follow those emergency services with standard counseling and support to the client or the client's family.*

Signature(s) _____Date: _____

Financial/Insurance issues: Currently I will only be accepting Blue Cross Blue Shield (BCBS) and State (ABS) insurance plans. If you have coverage with another insurance company, as a courtesy
I will provide a receipt with which you can file with your own insurance. We ask that at each session you pay your co-pay or 50% of the fee. These fees can be paid by either check or credit card. ***In the event you have not met your deductible, the full fee is due at each session.*** If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds S300.00, I will need to ask that you pay for services when rendered. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). Lastly, 1 ask that every client authorize payment of medical benefits directly to Tenecia M Bullock, LPC. I sincerely appreciate your cooperation. If you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

Signature(s) _____ Date _____

The following are the* Fees *for Services Rendered (revised 3/1/2014):

Services	CPT Codes	Amount
Initial Evaluation (50-60 minutes	90791	$200.00
Individual Psychotherapy (20 minutes)	90832	$90.00
Individual Psychotherapy (40 minutes)	90834	$150.00
Individual Psychotherapy (53-60 minutes	90837	$210.00
Family Psychotherapy (50 minutes w/pt) w/o pt	90847 90846	$185.00 $155.00
Group Therapy (80 minutes)	90853	$65.00
Misc:		

I have read and understand the current fee schedule. Please initial:_____

Lastly, if you need to cancel or reschedule* an *appointment, please give* 48 *<u>business hours advance notice,</u> otherwise <u>you will be billed at the mauler hourly rate.</u> I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments* please feel free *to ask. You may have a copy of this form if requested.

Signature(s):_____ Date: _____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one* ***year Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer*** to decline consent *no information will be shared.*

_____You may inform my physician(s) **_ ____ I decline to inform my Physician**

PHYSICIAN NAME:

CLINIC:

ADDRESS:

PHONE: ( )

Signature(s):_____ **Date_____**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

1/We consent that _____ ***may be treated*** *as a client* ***by Tenecia M Bullock, LAC. All appointments will be after hours i.e. 4:00*** *p.m. or later unless other arrangements have been made. It may be necessary* ***for the guardian to remain present in waiting area while session is being conducted. We ask for your cooperation in order that, we provide the timeliest treatment for you and your children.***

Signature(s):_____ Date: _____

AGREEMENT ON SUBPOENA AND INDEMNIFICATION

By *signing this agreement, I* as a client or as the parent/guardian of a client agree to the following terms:

1. I will not attempt to compel Tenecia Bullock's appearance in court, individually or as a representative of Broader Spectrum Counseling, PLLC, in a *deposition or* in any aspect of *a litigated* matter;

2. If I do attempt to compel Tenecia Bullock's appearance in any matter contrary to provision #1, I agree to compensate Tenecia Bullock for her time at the rate of Two Hundred Fifty Dollars ($250.00) per hour including preparation time, travel time, waiting time, deposition time and presentation time with a minimum of four hours AND to indemnify Tenecia Bullock for any attorney's fees she may incur as the result of my actions.

3. If a non-party to this agreement attempts to compel Tenecia Bullock's appearance, individually or as a representative of Broader Spectrum Counseling, PLIC, as a direct result of this counseling relationship, I agree to indemnify Tenecia Bullock and to reimburse her for any attorney's fees she may incur in defending against such an effort to compel her participation in a litigated matter.

4. Finally, I agree to indemnify Tenecia Bullock for any attorney's fees she may incur as a result of her efforts to enforce this agreement.

Witness my signature, this _____ day of_____, 20_____

_____Patient, parent or guardian.

_____Witness.

HIPPA 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 INFORMATIION. PLEASE REVIEW IT CAREFULLY.*

Effective date: January **1, 2007**

Tenecia M Bullock, LPC has been and will always be totally committed to maintaining client's confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT. I *may* need to use or *disclose health* information *about you* to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources

PAYMENT. Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as *information needed for billing and* **collection purposes. I may bill the person in your family who pays for your insurance.**

HEALTHCARE OPERATIONS. I may need to use information about you to review our treatment procedures and business activity.
Information maybe used for certification, **compliance and licensing activities.**

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Mississippi Stare Law, we are obligated to report this to the Department of Human Services. **If** you provide information that informs us, that you are in danger of harming yourself or others. Information to *remind* you of */or* to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Broader Spectrum Counseling PLLC Credit Card Authorization Agreement

By signing this agreement I an authorizing Tenecia Bullock-Funches, DBA Broader Spectrum Counseling PLLC to bill my credit card, health Savings account card, flexible insurance spending account card, checking account, or debit card for all professional services rendered to me, my spouse or on behalf of my minor children or other family members. I agree not to dispute any charges which may include but are not limited to the following:

Returned check fee of the initial check dollar amount and additional $40 fee. Initial ____

Any insurance deductibles, administrative fees, co-pays or excluded services or other charges not directly reimbursed by Tenecia Bullock-Punches DBA Broader Spectrum Counseling PLLC from my/our health insurance plan. Initial _____

I agree that telephone contact with Tenecia Bullock- Punches DBA Broader Spectrum Counseling PLLC in excess of 15 minutes other than that associated with normal scheduling services will be billed at the rate of $31.25 per 15 minute period. Initial _____

I understand that this form is valid until canceled in writing. Initial_____

Credit Card Type: MasterCard _____Visa___ Discover ____ American Express ____

Health Savings Account Card _____ Flexible Savings Account Card _____

Credit Card Number:_____

Expiration Date: _____

Name as Printed on Card: Zip Code: _____

Security Code:_____

Billing Address:_____

City: _____ State: __

Print Name:
_____

Signature:
_____

Date:_____

Addendum

Availability: The therapist is available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be made by calling the office number during regular office hours.

Emergency: In the event of an emergency, please contact 911. If it is an issue that cannot wait until the next therapy session, (after calling emergency personnel) you may call the office number, as I sometimes forward calls to in), cell phone. If you need to speak with someone urgently about an issue, and I am unavailable, please feel free to call Contact the Crisis line at 601-713-4357. This is a 24 hour crisis line.

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist. The usual minimal termination for an ongoing treatment process is four to ten sessions but a satisfying termination to long-term work may take a number of months.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may **be** emotionally painful at times. Patients have the right to refuse or to discontinue services at any time, and \complaints can be addressed to the MS Counseling Licensing Board.

Thank You