Milestones
Therapeutic
Center
www.milestonestherapyhamilton.com

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Client Registration Form

Client Name: _____ **Gender:** _____ **DOB:** _____ **Age:**____

Address:_____ City:_____ State:_____ Zip:_____

Social Security: _____ School:_____ Grade: _____

Client Cell Phone #: _____ Client Email: _____

Legal Guardian:_____ Relationship: _____ Phone #: _____

Guardian Email:_____ Guardian SSN:_____

Primary Insurance:_____ Member ID:_____ Group:_____

Policy Holder:_____ Relationship:_____ DOB:__ /__ /__ Co-pay:____ Deductible:_____

Secondary Insurance:_____ Member ID:_____ Group:_____

Policy Holder:_____ Relationship:_____ DOB:__ /__ /__ Co-pay:____ Deductible:_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

***Please initial each box granting permission to communicate in the following methods.**

Milestones Therapeutic Center, LLC has taken precautions to ensure that email is encrypted and HIPAA compliant. However, there may be some level of risk that protected health information in an email could be read by a third party. If clients agree to email or texting communication, Milestones Therapeutic Center, LLC is not responsible for unauthorized access to information emailed/texted or for safeguarding information once delivered to clients.

Types of Communication	**Text**	**Voicemail**	**Email**
Appointment reminders			
Mental Health/Medical information and progress			
Payment information			

_____

Client/Parent/Guardian Signature Date

_____

Provider Signature/Credentials Date

Informed Consent for Mental Health Therapy

Client Name: _____ Date: _____

Assessment

An assessment is completed for all clients at intake. The purpose of the assessment is to gather sufficient information from clients and guardians to identify the needs and preferences of each person served. This assessment may take more than one session and is focused on identifying problems as well as client strengths. It is preferred that this process be completed by the guardian(s) only and that children are not present.

Treatment Planning

Clients will actively participate in the development of an individual treatment plan once the assessment is completed. The plan will include needs, preferences, and strengths as well as identified problems, goals and objectives.

Attendance

Whenever possible, each client will have a reserved day and time at which weekly sessions will occur. If you know that you will not be able to attend your session on a particular day, please contact your therapist as soon as possible. No shows and cancellations that occur less than 24 hours in advance will be charged a fee. After three non-consecutive no shows without call or 5 late cancellations, the client will be removed from the schedule until further contact is made. This could result in the loss of the previously reserved session time.

Payments

Each client is responsible for the costs of services rendered. Milestones Therapeutic Center, LLC accepts several private insurance and Medicaid providers in an effort to provide the most cost effective services. Clients will be held responsible for any and all copays as required by their insurance companies, as well as any claims denied by those insurance companies. Milestones Therapeutic Center, LLC is able to accept cash, check and credit card payments (through Square) from clients.

Hours and Contact Information

The hours of availability for Milestones Therapeutic Center, LLC vary based on client needs. For mental health emergencies outside of scheduled appointment times, call 911 or contact your local crisis line.

- Butler County Crisis Line - 513-881-7180
- Hamilton County Care Team @ Talbert House - 513-281-2273
- National Crisis Line - 1-800-273-TALK (8255)
- Warren County Crisis Line - 1-877-695-NEED (6333)
- Crisis Text Line - Text CONNECT to 741741

Confidentiality

All client information including identifying information, diagnosis, and treatment will remain strictly confidential, as governed by the State and Federal laws, rules and regulations. Client information shall not be disclosed unless one of the following situations occurs:

1) imminent safety risk - threat of danger to self or someone else
2) suspected child/adult abuse or neglect
3) record review/case audit
4) contacting emergency contact
5) subpoena of records
6) nonresidential parent requests records
7) billing to insurance providers

Milestones Therapeutic Center, LLC may consult with other mental health professionals regarding the management of cases. The purpose of this consultation is to ensure quality care. The identity of the client is not disclosed during clinical consultation.

Both law and professional standards protect mental health records. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging to provide you with the full records directly, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. All client records are kept in Google Drive, which is a HIPPA compliant (secure and confidential) system. Progress notes are signed electronically by therapists.

I have received and reviewed:
_____Milestones Therapeutic Center, LLC Client Rights Statement and Grievance Procedure
_____Milestones Therapeutic Center, LLC Notice of Privacy Practices

I _____ (client/guardian name) give permission for Milestones Therapeutic Center, LLC to provide mental health treatment for _____(client).

I consent to participation in the following services: (please initial all that apply)
_____Individual Therapy
_____Group Therapy

If signed by a guardian, I acknowledge that I have the legal right to consent for my child to receive treatment.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all mental health treatments with my clinician.

Client/Guardian Signature Date

Therapist Signature/Credentials Date

Fee Agreement

Client Name:_____ **Date:**_____

Insurance Provider

_____ **Medicaid:** Aetna Better Health Amerigroup Buckeye Caresource Molina Healthcare
Ohio Medicaid Paramount Advantage Tricare West United Healthcare Community Plan of Ohio

_____ **Private Insurance:** Aetna Anthem Anthem Federal Cigna Humana Humana Military
Medical Mutual United Healthcare Optum UMR Multiplan Other: _____
Copay:_____Deductible:_____

Each person is responsible for his/her copayment and/or deductible. If you have a deductible to meet, you will pay the self pay rates below on the date of service. If the copay or deductible is higher than the rates below, it is your responsibility to pay the remaining balance to Milestones Therapeutic Center, LLC upon notification until your deductible is met.

Self Pay Rates:

Diagnostic Assessment:	$115-127
Therapy Session:	
• 60 minutes	$94
• 45 minutes	$68
• 30 minutes	$53
Group Therapy Session	$32
Missed Appointment/Late Cancellation:	$50
Letters	$50/$250
Written Reports	$110 p/h

Court related appearances: $375 per hour (4-hour minimum required; not covered by insurance
Consultation fees: $25 per 15 minutes (This includes attending parent teacher conferences, attending school meetings, conducting classroom observations, interacting with insurance providers, and other interactions upon your request.)

Client Responsibilities and Fee Information (please initial each box)

☐ Each person is expected to pay his/her fee at the time of service.

☐ A 2% processing fee will be rendered for all monthly bills paid by credit/debit card. An additional $1 fee will be charged for each in office transaction.

☐ Notify your therapist if there are any changes to your insurance benefits or if your insurance is discontinued.

☐ No shows or cancellations without a 24 hour notice will be charged $50.00, which is not reimbursable by insurance.

☐ All inquiries into pre-certification, benefits, treatment plans (if necessary), coverage, etc. are the client's responsibility.

☐ Payment is expected at the time of service and the client has the ultimate responsibility for their account and making sure insurance payment is received if using insurance. If a claim is denied it is the client's responsibility to pay their account upon notification of denial at the insurance reimbursement rate.

☐ If payment is not received for services rendered in a timely manner, I understand that Milestones Therapeutic Center, LLC will release my information to a third party Credit agency to attempt to collect my debt. The information provided to the Credit agency will only be demographic information in order to collect this debt.

☐ Milestones Therapeutic Center, LLC has your permission to release your protected health information to your insurance company to submit billing claims. You authorize Milestones Therapeutic Center, LLC to be paid directly by your insurance company.

☐ In order to receive services from Milestones Therapeutic Center, LLC you are agreeing to the conditions outlined above.

_____

Client or Parent/Legal Guardian Signature Relationship to Client Date

_____

Therapist Signature Date