Desoto Family Counseling
& Pediatric Therapy Center
FINDING SILVER LININGS SINCE 2001

PHYSICAL ADDRESS: 8626 AIRWAYS BLVD
MAILING/BILLING: P.O. BOX 1980
SOUTHAVEN, MS 38671
BEHAVIORAL HEALTH PHONE | 662.772.5937
PHYSICAL HEALTH PHONE | 662.510.8444
SECURE FAX | 662.772.5940

WELCOME TO DESOTO FAMILY COUNSELING CENTER

We are glad you have chosen to become one of our new patient's! **PLEASE** complete each section to completion with the best of your ability! We value our patient's and want to ensure you're given the **best care possible**! If you have any questions while completing this packet - please do not hesitate to ask one of our office members for assistance! Thank you so much for choosing Desoto Family Counseling Center!

[PATIENT INFORMATION]

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ | _____ | _____ SOCIAL SECURITY # _____ | _____ | _____ GENDER [MALE] [FEMALE]

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS - [SINGLE] [MARRIED] [WIDOWED] [DIVORCED] [SEPARATED] SPOUSE NAME [IF MARRIED] _____

EMAIL ADDRESS: _____

CELL # _____ | _____ | _____ HOME # _____ | _____ | _____

[FINANCIALLY RESPONSIBLE PARTY - IF OTHER THAN PATIENT]

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____ | _____ | _____ SEX [MALE] [FEMALE]

LAST NAME _____ FIRST NAME _____ MI _____

SOCIAL SECURITY # _____ | _____ | _____ PHONE # _____ | _____ | _____

[INSURANCE INFORMATION]

PRIMARY _____ SECONDARY [IF APPLICABLE] _____

PRIMARY ID _____ GROUP #_____ SECONDARY ID _____GROUP # _____

[SUBSCRIBER INFORMATION - IF OTHER THAN PATIENT]

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ | _____ | _____ SOCIAL SECURITY # _____ | _____ | _____ SEX [MALE] [FEMALE]

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL # _____ | _____ | _____ HOME # _____ | _____ | _____

[EMERGENCY CONTACT INFORMATION]

NAME _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ | _____ | _____ PHONE # _____ | _____ | _____

By signing below, I am confirming that all the information I have provided is true to the best of my knowledge.

PATIENT SIGNATURE _____ **DATE** _____

[AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ PAYMENT OF INSURANCE BENEFITS]

I hereby authorize Desoto Family Counseling Center, PLLC, along with my attending physician, permission to disclose any information from my personal medical records to insurance companies and/or outpatient benefit programs pertaining to my treatment as needed when processing insurance claims. If needed for treatment, I authorize Desoto Family Counseling, PLLC to release information pertaining to any medical screenings (drug/genetic/pregnancy) to third party processors. Furthermore, I assign payment directly to Desoto Family Counseling, PLLC wherein specified and otherwise payable to me but not to exceed any charges rendered by Desoto Family Counseling, PLLC for receiving mental health and/or medical treatment. I understand that I am personally responsible for any charges that are not covered by this authorization.

PATIENT SIGNATURE _____ DATE _____

[FINANCIAL GUIDELINES]

Please be prepared to pay your copay/co-insurance/self-pay/or towards your deductible at your scheduled appointment time. We require payment to be given **AT** the time of service. Our facility accepts all major credit cards, cash, and **SOME** HSA/FSA cards. If for some reason your HSA/FSA card does not work/declines your payment - we can print the patient an itemized receipt that can be sent to your HSA/FSA company for reimbursement. If you have read our financial policies in completion and agree to comply, please sign and date below.

PATIENT SIGNATURE _____ DATE _____

[PATIENT COMMUNICATION]

Our office staff is available by phone every Monday through Friday during business hours [8:00 to 6:00] [Lunch 12:15 to 12:45]. Any scheduling, billing, insurance, or medication inquiries can be made by telephone or in the office. If you need to leave a message for your physician or therapist directly, the front staff will document the information from the caller and give the message to your specified provider. We ask that you give your providers 24-48 hours to follow up with you directly. If the message is regarding a prescription refill, we also ask that you allow 24-48 hours for your refill to be called in. There is always a possibility there may be some delay time regarding your refill requests due to the physician's necessity to review the patient's chart thoroughly and determine course of action needed. If for some reason you call our office and your call goes unanswered, we ask that you leave a voicemail and allow our staff to call you back as soon as possible. If you have read the terms regarding patient communication at Desoto Family Counseling, PLLC and are in agreeance to follow them as a patient at our facility, please sign below.

PATIENT SIGNATURE _____ DATE _____

[MEDICARE PATIENT'S ONLY – STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN]

I certify that the information given by me in applying for payments under the Title XVII of the Social Security Administration or its intermediaries or carriers consists of the accurate information needed for Medicare claims. I request that all authorized benefits payments be made on my behalf. I assign the benefits payments for physician services to the physician or organization furnishing the services along with the authorization to submit any claims to Medicare for payment. By signing below, I am agreeing to these terms set by Desoto Family Counseling, PLLC regarding the insured's Medicare.

PATIENT SIGNATURE _____ DATE _____

[APPOINTMENT POLICY]

Our office policy requires **ALL** appointments needing to be **cancelled** and/or **rescheduled** by **1:00 PM** the day **PRIOR** to your appointment. We have this policy set in place so that our providers are given the opportunity to fill in any cancellations that may arise. If a patient cancels and/or reschedules an appointment **LATER** THAN **1:00 PM** the day **PRIOR** to their appointment – that will be considered a **LATE CANCELLATION**. If a patient fails to cancel an appointment altogether – that will be considered a **NO SHOW.** There is a **$60 fee** attached to **EACH** no show or late cancellation the patient receives. If the patient has **2 consecutive** late cancellations or no shows in a row, the provider has the right to put all **future appointments on hold** until reason for cancellations and no shows are discussed with patient. If the **problem persists once discussed**, the provider then has the right to refer the patient to another mental health facility and terminate services within Desoto Family Counseling Center. If a patient ever wants to dispute that an appointment was cancelled within the time stated by our policy, we ask that you **address** the matter with your **provider** and in turn the solution can be passed on to our Front Staff.

If you have read, and agree to, all the terms regarding our appointment cancellation policy please sign below.

PATIENT SIGNATURE _____ DATE _____

[TECHNOLOGY GUIDELINES]

Desoto Family Counseling values the privacy and confidentiality of each patient utilizing services through our facility. There are a few guidelines regarding technology that is available for our patients to utilize throughout their time here at DFCC.

- If you choose to receive an appointment reminder via text message – you will receive the reminder **48 hours prior** to your scheduled appointment time. Upon arrival of the text reminder – it is the PATIENT'S responsibility to respond [yes] or [no] by 1:00 PM the day **prior** to your appointment (as previously stated regarding appointment rescheduling).
- Please be aware that although Desoto Family Counseling operates through a **secure**, HIPAA compliant browser, if you and your provider communicate via email, most common browsers such as **Gmail** or **Yahoo** are **NOT** secure browsers.
- Desoto Family Counseling is **not** under any circumstance authorized to send medical records via email to an unsecured browser.
- None of our providers can give any of their personal cell phone numbers to patients at any time. If you are experiencing an **emergency** – we urge you to call your local **acute care facility** OR call **911**.
- Our staff desires to uphold the most professional and secure environment possible. Unfortunately, we **cannot** accept any requests from patients via Facebook, Snapchat, Instagram, etc. We ask that **no contact** via **social media** be made to any of your providers here at Desoto Family Counseling Center due to conflict of interest.

If you have read and agree to follow all terms and guidelines referring to patient use of technology here at Desoto Family Counseling Center, please sign below.

PATIENT SIGNATURE _____ DATE _____

[DECISION TO TERMINATE]

At Desoto Family Counseling Center, we strive to provide you with the best care that you, your family, or your child may need. However, the therapist oversees the provider/client relationship and may deem it appropriate to terminate services. The following examples of termination reasoning include, but not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy services, or that the client would benefit from another therapist. The therapist will discuss the decision to terminate with the client or will send a letter notifying of the decision to terminate along with referral options.

The client or client's representative also has the right to terminate services during the therapy process.

By signing below, I understand the decision to terminate and agree to comply with this policy.

PATIENT SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____

[ACKNOWLEDGEMENT OF PRIVACY PRACTICES]

I, _____ , have been presented with a copy of Desoto Family Counseling Center's Patient Notification of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of the notification. By law, Desoto Family Counseling Center is required to obtain your signature indicating you have received this document. Your signature does not surrender any rights or confidentiality protected by HIPAA.

PATIENT SIGNATURE _____ DATE _____

[INTERNAL USE ONLY]

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

PRESENTED ON [DATE & TIME] _____

BY [NAME & TITLE] _____

[CLIENTS WITH DIVORCED PARENTS/GUARDIANS]

Desoto Family Counseling Center requires that all custody paperwork be presented at the time of the appointment, so our staff can keep an updated record of the patient's current custody agreement. Any services not covered by insurance should be paid for by whichever party is in financial obligation of the child. If the parent that is not financially responsible for the patient is the one bringing the child to the appointments, it is your responsibility to collect required payment from the responsible party. The responsible party will need to sign a form stating they are aware of their responsibility to provide all payments that are not covered by the child's insurance. We require payment at the time of services, however, we will try our best to accommodate your situation if an unforeseen circumstance were to arise.

If you understand and agree to follow our policy regarding the financially responsible within divorced parents/guardians, please sign below.

PATIENT SIGNATURE _____ DATE _____

[DESOTO FAMILY COUNSELING FEE SCHEDULE]

The following is Desoto Family Counseling Center's self-pay fee schedule and what will be billed to your insurance, if filing to insurance. This is not what the patient will owe at the time of service. All rates are subject to change and are updated periodically. Please let the front staff know if you have any questions regarding our fees.

MEDICATION MANAGEMENT [INITIAL]	$175 [PLUS DRUG SCREEN FEE FOR ADULT]
MEDICATIAN MANAGEMENT [FOLLOW-UP]	$75 - $130 [BASED ON TIME SPENT WITH PROVIDER]
THERAPY [INITIAL]	$195
THERAPY [FOLLOW-UP]	$130 - $200 [BASED ON TIME SPENT WITH PROVIDER]
THERAPY [WITH PATIENT]	$150
THERAPY [WITHOUT PATIENT]	$130
NO SHOW/LATE CANCELLATION FEE	$60
OT/PT/SLP Evaluations	$100 - $395
OT/PT/SLP F/U Treatments	$65 - $260 [BASED ON TIME SPENT WITH PROVIDER]
MEDICAL RECORDS	$25 [1 TO 25 SHEETS]
ADDITIONAL SHEETS [RE: MEDICAL RECORDS]	$1 [EVERY SHEET AFTER]
TREATMENT SUMMARY	$250 [STARTING AT]
BASIC LETTER FEE / DISABILITY PAPERWORK	$25
DRUG SCREEN [NOT COVERED BY INSURANCE]	$25
PREGNANCY TEST [WOMAN OF CHILD BEARING AGE ONLY]	$8
THERAPIST/LAWYER CONSULTATION [COURT RELATED]	$1,000
COURTROOM TESTIMONY – HALF DAY	$3,500
COURTROON TESTIMONY – FULL DAY	$5,000

[AUTHORIZATION TO RELEASE LIMITED INFORMATION]

Desoto Family Counseling Center offer's an automated call/text service that will contact you two business days ahead of time to remind you of your appointment. The automated call will give the message to anyone who answers or leave a voicemail if reached. The automated text will include the provider's name, appointment date and time, and the client's name. Please take care to protect your phone from anyone you do not want to have this information.

Please note that Desoto Family Counseling Center cannot guarantee you will get a reminder call/text in the event we have difficulty reaching you on the number designated below. Also, appointment reminder call/text are provided as a courtesy, and we ask that you keep up with your appointment times in the event we're unable to call/text.

Please choose one of the following options:

_____ No, I do not want Desoto Family Counseling Center to make reminder calls for my appointment times.

_____ Yes, I do want Desoto Family Counseling Center to contact me only via phone call/voicemail at # _____

_____ Yes, I do want Desoto Family Counseling Center to contact me only via text messaging at # _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

[RELEASE OF INFORMATION FOR FAMILY AND/OR FRIENDS OF THE CLIENT]

If there is anyone, other than the client, that may call and check limited information on the account (example: check appointment times, pick up a prescription/samples, pay a bill, transport a minor, etc..) please list these names below (including parents/legal guardians if patient is under 18) and specify what information they may access. No other information, other than what you list, will be released.

Note: This is not a full medical records access request. That will still require a separate release of information to be signed. If no one other than the patient, please state "NONE".

Name	Relationship
Phone Number	What can be released?
Name	Relationship
Phone Number	What can be released?
Name	Relationship
Phone Number	What can be released?
Name	Relationship
Phone Number	What can be released?
Name	Relationship
Phone Number	What can be released?

You have the right to revoke this authorization, in writing, at any time. However, your revocation will not be effective to the extent that we have acted in reliance on the authorization.

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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SECURE FAX | 662.772.5940

Authorization to Release Healthcare Information

Patient's Name _____ Date of Birth _____

Legal Guardian's Name (if applicable) _____

I authorize Desoto Family Counseling Center to (*circle one*) RELEASE / OBTAIN / EXCHANGE records with

Provider/ Office Name _____

Address _____

Phone _____ Fax _____

I authorize the release of:

_____ All Progress Notes

_____ Other Specific Information _____

This authorization shall remain in effect until _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Desoto Family Counseling Center. However, your revocation will not be effective to the extent that we have acted in reliance on the authorization.

_____ _____
Signature of Patient/Guardian *Date*

_____ _____
Witness *Date*

Basic Identity and Contact Information

Name: _____ Date of birth: _____
Parent's name: _____
Address: _____ Phone number(s): _____

Background Information

Language spoken in home: _____ Number of siblings and ages: _____ School: _____
Grade: _____
Concerns regarding performance at school: _____
_____
_____

Birth History

Weight: _____ Length: _____ Type of delivery (please circle): Vaginal C-section Emergency C-section Was there anything unusual about the pregnancy or birth? Please describe. _____
_____
How old was the mother at birth? _____ Was the mother sick during pregnancy? Please describe. _____
_____
How long was the baby's hospital stay after birth? _____ Did the baby receive any medication or treatment during the hospital stay? Please describe. _____
_____

Medical History

Is the child currently taking any medications? Please describe. _____
_____
Please describe any diagnosis the child has received from a physician or therapist below. _____
_____
Please list any surgeries: _____
Please list any other serious injuries: _____
_____
Is the child currently (or recently) under a physician's care for a condition? Please describe. _____
_____
Has your child's hearing been tested recently? Please provide date and results below. _____
_____

Developmental History

Please give the approximate age your child achieved the following developmental milestones:
_____ Sat alone _____ Babbled _____ Crawl _____ First word _____Walked _____ Put 2 words together

Speech and Language History

Describe any speech and/or language problem below. _____
_____
_____

When was the problem first noticed? _____

_____

Has the problem become better or worse? Please describe. _____

_____

Have you received any speech therapy or other treatment? Please describe treatment and results. _____

_____

_____

Is there a family history of speech and/or language delays? Please describe. _____

_____

_____

_____

Swallowing

Current diet: _____ What utensils/devices/cups/etc are being utilized during feedings? _____

_____

How often are feedings? _____ Current weight: _____ Current Height: _____

Any difficulty gaining/maintaining weight? Please describe. _____

_____

Any gastrointestinal issues? Please describe. _____

_____

Describe any swallowing problem below. _____

_____

_____When was the problem first noticed? _____

Has the problem become better or worse? Please describe. _____

_____

Have you received any speech therapy or other treatment? Please describe treatment and results. _____

_____

_____

If there is any other information that is pertinent to this evaluation, please note: _____

_____

_____