"Welcome To Our Office"

Since1977

The Miami Counseling & Resource Center ("MCRC") is a large, private Center that has been helping individuals, couples, and families in Miami for over 30 years, and we are pleased to make available our services to you and your family. Our responsibility lies in providing diagnostic and therapeutic interventions for the relational, emotional, and psychological difficulties you and/or your family are currently experiencing. We have a team that includes the following disciplines:

- *mental health counselors*
- *marriage & family therapists*
- *social workers*
- *psychologists*
- *psychiatrists*
- *nutritionists*

Our office is open six days a week with flexible hours. Your individual clinician will help coordinate treatment for you. Communication with that person is important so the following information will be helpful:

- (305) 448-8325 *Your Clinician* *ext. #*_____
- (305) 448-8325 *Our Front Office* *ext. #* 7
- (305) 448-0687 *Facsimile*
- *www.miamicounseling.com*

Because we do not offer EMERGENCY services, please call 911, the Switchboard of Miami at (305) 358-help (4357), or go to your nearest emergency room when you are undergoing an emergency situation.

Enclosed you will find some forms that will aid us in assisting you more effectively. Please take the time to fill them out completely.

OFFICE POLICIES

In order to ensure quality service, we offer the following policies and procedures to help you understand our Center's way of operating and to make your experience here more positive and comfortable.

CANCELLATIONS

If you cannot attend a scheduled appointment, kindly notify us as soon as possible. Be aware that you will be charged for any appointment that is not cancelled twenty-four (24) hours in advance. Please be mindful that your treatment provider reserves an hour especially for you and may be unable to fill that time on short notice. You will be solely responsible for the full fee, since we cannot bill your insurance for a service not provided. (If you have a Managed Care plan, alternative policies may apply.)

SESSION LENGTH

Therapy: Individual, couple and family therapy sessions are 45-50 minutes in length. The fee will be assessed on a prorated basis should the session exceed 50 minutes.

Psychiatry: Initial psychiatric evaluations are 60 minutes, follow-up medication sessions are 20-30 minutes, and therapy is 45-50 minutes.

Nutrition: Initial nutritional evaluations are 75 minutes and follow-up sessions are 30 minutes.

FEES & PAYMENTS

Your hourly fee will be discussed with your individual clinician as well as with our intake coordinator. If your hourly fee has not already been established, you may discuss this with your treatment provider.

Our office prefers payment to be made by check or cash, and we also accept credit cards. **Checks are to be made to MCRC (or Miami Counseling & Resource Center).** There is a **$25.00** service charge for a check that is returned from the bank.

Miami Counseling and Resource Center will verify insurance coverage with your insurance carrier. However, verification of benefits does not guarantee payment. Parties are responsible for the full fee due if the insurance carrier denies the claims or fails to pay the anticipated charges.

NON-SESSION CONSULTATION

In addition to scheduled sessions, other services will be charged at the hourly rate on a prorated basis. Other services include phone consultations (e.g., with the client, family members, other professionals), report writing, and letters. Legal appearances are billed at a higher rate. Quick phone contacts (less than 5 minutes) are not billed.

CONFIDENTIALITY AND INFORMED CONSENT

I understand that my right to privacy is protected by federal and state laws and that I am the holder of privilege within the client/clinician setting. I understand that this means information discussed during treatment at Miami Counseling & Resource Center ("MCRC") is confidential and that no information can be released to anyone outside MCRC without prior authorization from me, with certain exceptions, as outlined below:

1) I understand and give permission for my clinician to consult with other professionals and employees at MCRC since they are members of MCRC's own in-house treatment team, which may include therapists, nutritionists, psychiatrists, or another therapist who is seeing other members of my family.
It may be necessary at times to share routine information with a physician, nutritionist, psychiatrist, school or trust counselor, or other professional in the community who is treating or involved with you in some way. These disclosures will be discussed with you in advance and you will be asked for a signed consent prior to any such disclosure.

2) I understand that there are several exceptions to the client/clinician privilege. Your clinician is obligated under law to report the following:

a. child abuse
b. elder abuse
c. abuse of disabled or mentally ill persons
d. when required by court order
e. harm or potential harm to self or others ("Duty to Warn")

3) I understand that if I choose to use health insurance to cover the cost of treatment, protected health information (PHI)is frequently required by the insurance companies in order to access benefits and determine medical necessity. By signing below I am consenting to the use and disclosure of protected health information (PHI) with insurance companies by MCRC for purposes of treatment, payment, and health care operations.

4) Because privacy in treatment is often crucial to successful progress, I understand and agree that treatment for children and adolescents may require that the parents or guardians waive their right to their children's records. We will provide the parents/guardians with general information about the progress of the child's treatment and attendance at sessions. If we feel, however, that the child is in danger or is a danger to someone else, we will notify the parents of this concern.

5) I understand that communication and web-based scheduling over the internet, using the electronic email system, and text messaging via mobile devices are not always encrypted, not a confidential system, and inherently insecure. There is no assurance of confidentiality when communication is done in this way. Nevertheless, I agree to its use in my treatment as a means of communication and sharing of treatment or testing information. I agree to communication in this manner and accept full responsibility for information sent to my email address (s), mobile devices, and/or other information transmitted via the internet.

6) I understand it is my responsibility to protect the device used during online counseling to ensure confidentiality. I am aware that online therapy is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. I agree that online communications are confidential and all record between client and clinician remain the property of Miami Counseling & Resource Center (MCRC).

7) I understand that neither Miami Counseling & Resource Center (MCRC) nor my clinician provides supervision for minors who are in our building. Arrangements for their supervision need to be made by me in advance and their supervision is my responsibility.

INFORMED CONSENT AND AUTHORIZATION FOR TESTING AND TREATMENT

I am aware that the Notice of Privacy Practices for Protected Health Information (PHI) is posted in the waiting room and I have received a copy. I have read and understand the information contained on the prior pages of this form. My signature below indicates my understanding and agreement to this information, and I hereby consent to the professional procedures deemed appropriate for evaluation and treatment; and where treatment is for a minor, I am authorized to consent for his/her evaluation and treatment.

_____ _____
Patient's Signature Parent/Guardian's Signature

_____ _____
Parent/Guardian's Signature

_____

_____

_____ _____
Clinician's Signature Date

CONSENT FOR INTERENT/EMAIL/TEXT COMMUNICATIONS AND SCHEDULING

Communications using the internet, the email system, text messaging and web-based scheduling, are not always encrypted. There is no assurance of confidentiality of information when communicated in this way. Nevertheless, you may request that we communicate with you via internet, email system, text messaging and web-based scheduling. To do so, you must initial and sign the following:

_____I agree to communication using the internet, the email system, text messaging and web-based scheduling.

_____I certify that my email address(es) and phone numbers provided here in this intake form or from other sources is (are) accurate, and that I, or my designee on my behalf, accept full responsibility for messages to and/or from any of these email address(es) and phone numbers.

_____I have read and received a copy of the Confidentiality and Informed Consent form and have read this Consent for Internet/Email/Text Communications and Scheduling.

_____I understand and acknowledge that communications over the internet, the email system, text messaging and web-based scheduling are not encrypted and are inherently insecure; there is no assurance of the confidentially of information (e.g., PHI) when communicated in this way.

_____I understand that all email communications in which I engage can be forwarded to other providers, including providers not associated with Miami Counseling & Resource Center, for purposes of providing treatment or testing services to me.

_____I agree to hold Miami Counseling & Resource Center, its staff, and my clinician(s) harmless from any and all claims and liabilities arising from or related to this Consent for Internet/Email/Text Communications and Scheduling.

SIGNATURE:_____**SIGNATURE:**_____

PRINT NAME:_____**PRINT NAME:**_____

DATE:_____**DATE:**_____

INTAKE INFORMATION

NAME:_____, _____**DATE:**_____
last first

ADDRESS:_____**APT:**_____

CITY:_____**STATE:**_____**ZIP:**_____

HOME PHONE:_____**WORK PHONE:**_____

CELLULAR/MOBILE :_____**FAX#:**_____

E-MAIL ADDRESS:_____ **SS#:**_____

May MCRC, your therapist(s), or psychiatrist call you at any one of the above phone numbers, leave the name of the person calling, and/or leave a message with someone or on voicemail?
_____Initials - Yes_____No_____
May MCRC, your therapist(s), or psychiatrist contact the person who referred you?
_____Initials - Yes_____No_____

SEX: M:____ F:____**AGE:**_____ **DATE OF BIRTH:**_____

MARITAL STATUS: MARRIED:_____ SINGLE:_____ DIVORCED:_____
SEPARATED:_____ WIDOWED:_____ LIVING WITH SIGNIFICANT OTHER:_____

PHARMACY: NAME: _____ PHONE _____
ADDRESS: _____ ZIP: _____

REFERRED BY:_____

If Internet: key words_____ search engine?_____

REASON FOR REFERRAL:_____

EMPLOYER / SCHOOL:_____ **OCCUPATION:**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

EMERGENCY CONTACT:
NAME:_____**RELATION TO YOU**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

HOME PHONE:_____ **WORK PHONE:**_____

CELL PHONE:_____

PRESENT HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER SIGNIFICANT FAMILY MEMBERS (Not living at home)

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIMARY CARE PHYSICIAN:

NAME:_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

PHONE NUMBER:_____**FAX NUMBER:**_____

MEDICAL HISTORY

Illnesses/Medical Conditions:_____

_____

Prescriptions/over the counter drugs:_____

_____

Allergies & Medications:_____

Tobacco, Alcohol & Drug Use History:_____

PREVIOUS PSYCHOTHERAPY/PSYCHIATRIC TREATMENT: YES_____NO_____

WITH WHOM:_____

HOW LONG:_____WHEN:_____

INSURANCE/BILLING INFORMATION: **INS. CO:**_____

INS.ID#:_____**AUTHORIZATION/REFERAL#**_____

Insured/Resp.Party:_____**D.O.B:**_____ **Relation:**_____

ADDRESS (If different):_____**CITY:**_____**STATE:**_____**ZIP:**_____

HOME NUMBER:(_____)_____**SS#**_____**EMPLOYER:**_____

WORK PHONE:_____

*__Please have available your Insurance ID card in order for us to photocopy.__

Our office prefers payment to be made by:

1) cash 2) check 3) debit card.

However, in an effort to avoid difficulties with your account, please provide credit card information in the space below.

This information will only be used in processing payment due to one or more of the following: copayment balance, returned bank checks, balance for insurance payments made directly to patients, missed or late cancelled appointments, denial of expected coverage by insurance companies or therapy session payment.

Thank you for your cooperation.

CREDIT CARD:

☐ **VISA**

☐ **MASTER CARD**

☐ **DISCOVER CARD**

NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3 DIGIT CODE ON BACK OF CARD ☐☐☐

EXPIRATION DATE: ☐☐☐☐

STREET ADDRESS:_____

CITY:_____**STATE:**_____
(Where statement is mailed)

ZIP CODE: ☐☐☐☐☐
(Where statement is mailed)

SIGNATURE:_____

PRINT NAME:_____

Financial Agreement
(MD/PSYCH)

I, _____, agree that the responsibility for the initial Psychiatric Evaluation charge of **$_____ (60 minutes)**. Follow up Medication Evaluation **$____ (30 minutes)** and Therapy **$_____ (45 minutes)**, at the Miami Counseling & Resource Center is mine. If at any time I terminate treatment and have any outstanding balance, I agree to pay that balance in full.

Telephone calls which exceed 15 minutes will be charged as a regular Follow-up visit **($_____).**

Because time has been reserved exclusively for me and/or my family members, I understand that a ***twenty-four (24) hour notice of cancellation is required***. In the event that the advance notice is not provided, I understand that I will be charged the full fee for the reserved appointment.

I authorize the Miami Counseling & Resource Center to file Insurance Claims on my behalf for my reimbursement.

Should it be necessary for the Miami Counseling & Resource Center to obtain the services of a collection agency and/or an attorney to collect an overdue balance, the undersigned agrees to pay all reasonable attorney's fees, collection expenses, and court costs incurred in any such action. Balances that have been outstanding over thirty (30) days will begin accruing interest at a rate of 1.5% per month. Interest will continue to accumulate on a monthly basis and will be added to the balance until the entire bill is paid.

_____ _____

Witness Signature

_____ _____

Date Date

_____

_____

Address