"Welcome To Our Office"

Since 1977

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 and/or using the electronic email system is 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 messages to my email address(s) and/or other information transmitted via the internet.

6) 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

REQUEST FOR INTERENT/EMAIL COMMUNICATIONS AND SCHEDULING

Communications over the internet, using the email system, and/or 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 email or via the internet. To do so, you must initial and sign the following:

_____I certify that my email address(es) 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).

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

_____I understand and acknowledge that communications over the internet, using the email system, and/or web-based scheduling are not 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 may 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 Request for Internet/Email 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:_____

REFERRED BY:_____

If Internet: keywords_____ 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.__

INSURANCE CONSENT

In order for you to better understand how your insurance works, we submit the following for your consideration:

Your insurance benefits may be limited, by the number of visits granted per calendar year or by the total annual dollar amount available under Your Mental and Nervous benefits. Furthermore, your insurance company, in the course of treatment, may impose limits on the number of visits you receive based on their definition of medical necessity criteria.

When we accept assignment of insurance benefits for pay of your bill, we are, in effect, acting as the insurance company's agent or provider. It's also important for you to understand information on your insurance form, we may be asked to discuss, in a verbal or written report, information related to your case with a case manager. A case manager is a clinical representative of the insurance company and this contact is often necessary to facilitate continuing payment for your psychotherapy.

I understand and have discussed the above conditions. I herby authorize you to the use and disclosure of protected health information (PHI)on my behalf for the purposes of precertification, billing, collections, and any other insurance-related function.

_____ _____

Date Patient

_____

Parent or Guardian

Lifetime Assignments*

SIGNATURE ON FILE AND ASSIGMENT OF BENEFITS AGREEMENT

Kindly accept a photocopy of this authorization as if it were an original executed authorization. I understand that the Miami Counseling & Resource Center will use my signature below as a signature on file. I authorize the release of any payment and medical information necessary to process my or my family members' claim or related claims.

SIGNED _____ (Patient)

SIGNED _____ (Insured)

I hereby authorize payment directly to the Miami Counseling & Resource Center of the insurance benefits otherwise payable to me for their professional services. I understand I am financially responsible to the Miami Counseling & Resource Center for all charges not covered by this assignment.

SIGNED _____ (Patient)

SIGNED _____ (Insured)

***Assignment is good for the duration of therapy and does not have to be renewed at the beginning of each calendar year.**

Financial Agreement(I)

I,_____, agree that the responsibility for the hourly charge of $_____at the Miami Counseling & Resource Center is mine. I agree to assign to the Miami Counseling & Resource Center any insurance benefits available to me. However, should said insurance not provide the expected coverage, I am fully responsible for the full agreed upon fee. I assume responsibility for familiarizing myself with my insurance benefits and limitations.

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. It is also understood that my insurance company is not responsible for fees that are incurred for missed appointments. Therefore, the full fee will be charged.

I am responsible for promptly responding to inquiries from my insurance carrier. If I fail to do so and payment is affected, I will be responsible for the charges incurred.

Should it be necessary for the Miami Counseling & Resource Center to obtain the services of a collection agency and/or and 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

PAYMENT METHODS: Since COVID, the use of credit cards for payments has soared, especially their use virtually. This has caused a significant increase in the cost of doing business. We would like to invite you to another method of payment, E-CHECK, which is free to you. We know this method is different and if you would like to continue using your credit card then we completely understand but regret the addition of a 2.5% surcharge. We do still accept check or cash. Thank you for your understanding.

1 **E-CHECK (0% FREE)**

CHECKING ☐ OR SAVINGS ☐ ACCOUNT #:

BANK ROUTING #:

2 **CREDIT CARD (2.5%)**

We impose a surcharge (2.5%) on credit cards that is not greater than our cost of acceptance.

☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

NUMBER:

SECURITY CODE: **EXPIRATION DATE:** **ZIP CODE:**

3 **WE ALSO ACCEPT CASH OR CHECKS PAYABLE TO "MCRC" (0% FREE)**

The above information will only be used in processing payment due to one or more of the following: fee for sessions, returned bank checks, missed or late cancelled appointments, or denial of expected coverage by insurance companies.

BILLING ADDRESS:_____

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

SIGNATURE:_____ **PRINT NAME:**_____

DATE:_____