Harm Reduction Center, LLC Intake Forms & Releases

Please fill out ALL sections. *Highlighted field means answer is REQUIRED*

<table>
<tr><td colspan="2">Full Name:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="2">DOB:</td><td colspan="2">Age:</td></tr>
<tr><td colspan="2">Cellphone Number:</td><td colspan="2">Full SSN:
-- --</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="2">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="4">Email Address:</td></tr>
<tr><td>Gender (circle one):
Male
Female
Transgender
Non-Binary
Wish not to disclose</td><td>What was your gender assigned at birth? **We are required to collect this information for medical purposes**
Female
Male</td><td colspan="2">Preferred Pronouns:
He/Him
She/Her
They/Them
Other:</td></tr>
<tr><td colspan="2">Ethnicity (circle one):
Hispanic/Latinx
Non-Hispanic/Latinx</td><td colspan="2">Race (circle one):
Black
White
Asian/Pacific Islander
Native American
Mixed
Other</td></tr>
<tr><td colspan="2">Are you seeking treatment for (circle one):
Substance Abuse
Mental Health
Other:</td><td colspan="2">Marital Status:</td></tr>
<tr><td colspan="2">Employer:</td><td colspan="2">Employer Phone Number:</td></tr>
<tr><td colspan="2">Occupation:</td><td colspan="2">Who Referred You?</td></tr>
<tr><td colspan="4">Referral Phone:</td></tr>
<tr><td colspan="2">Have you received treatment for the following in the past for mental health, substance abuse, or both?</td><td colspan="2">Have you been to Harm Reduction Center, LLC (HARC) before?
Yes
No</td></tr>
</table>

Please list out all treatment attempts/past treatment locations and timeframe:			
Current Medications (If you are on NO medications, please fill in 'N/A'):		**Have you experienced problems related to substance abuse and/or addiction?** Yes No	
If yes, please describe your history of substance abuse and/or addition:			
Have you been given a mental health diagnose in the past? Yes No	**If yes, please list out all mental health diagnoses:**		
Preferred Pharmacy and Address:		**Past and/or Current Medical Issues:**	
Food/Medication Allergies:			
Emergency Contact Name:		**Relationship:**	
Phone Number:			
Insurance Name:			**Member ID #:**
Group ID #:			**Subscriber Name:**
Relationship to Subscriber:			**Subscriber DOB:**

CONSENT FOR SERVICES & CLIENT RIGHTS

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. I understand that I may revoke this authorization at any time upon written notice to Harm Reduction Center LLC. I acknowledge that such revocation will not be effective if Harm Reduction Center LLC. has already acted in reliance upon this authorization. This authorization is valid (if not previously revoked) this consent will terminate upon 90 days from the date of signature of this form, or the following event/condition or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

Probation on Re-disclosure

This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR part 2 The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Cancellation Policy

Harm Reduction requires 48-hour notice in the event you need to cancel or reschedule your appointment. To cancel or reschedule your appointment contact your therapist by calling his / her direct dial phone number, or you may contact the front desk at 1(866) 205-1382 between 8:30am and 4:30pm, Monday through Friday.

Emergencies

Please discuss with your therapist how to handle emergencies. If you experience a mental health crisis outside of a session there are several resources for help. These resources are available 24 hours per day, 365 days per year. Alternatively, you may go to the nearest Emergency Room or call 911.

Fee and Insurances

The fee for your first appointment is determined by a Client Service Specialist during the intake process. Harm Reduction Center accepts cash, checks, MasterCard, Discover, and Visa. Harm Reduction accepts Medicare and some insurance as in-network, and other insurance as out-of-network. This varies per the individual therapist / provider, so please discuss this further with your therapist. If you select to use your insurance, we will assist you in answering basic questions about your benefits, as well as submit claims on your behalf. You will need to provide your current insurance identification care at the time of your initial appointment. Your plan may include deductibles, co-insurance, and co-pays. Ultimately, you are responsible for payment and understanding your insurance policy.

Print Name: ____ Date: ______________________

Signature: ____

CONSENT TO LEAVE VOICEMAIL AND/OR TEXT MESSAGES CONTAINING MEDICAL INFORMATION

Harm Reduction Center staff will not leave voicemails and/or text messages containing your medical information without your consent. Complete this form if you wish for Harm Reduction Center to leave voicemails and/or text messages containing your medical information.

By signing this form, you consent to Harm Reduction Center leaving voicemails and/or text messages containing your medical information on the phone number(s) listed below. This information may include, but is not limited to,

demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.).

I, the undersigned, consent to voicemails containing my medical information at the following phone number(s):

Primary Phone: ___________________________________ (**Text or Call**- Please Circle One or Both)

Alternate Phone (Optional): ___________________________________ **(Text or Call**- Please Circle One or Both)

I understand that Harm Reduction Center cannot require me to sign this form in order to receive treatment. I understand that I am entitled to a copy of this completed form.

I understand that I have the right to revoke this consent at any time by sending a written request to Harm Reduction Center. My decision to revoke this consent does not apply to information disclosed in a voicemail prior to the date of revocation.

By my signature below, I certify that I have read and understood the items on this form, that I have given truthful information about my identity, and that I am either the patient or the patient's legally authorized representative.

Print Name: ____ Date: ________________________

Signature: ____

FINANCIAL AGREEMENT

The following constitutes the financial policy of Harm Reduction Center, hereinafter "clinic", with respect to services rendered at this clinic.

1. Clinic will bill insurance carriers on behalf of the Patient where applicable. This is a service we provide for our Patients. The Patient is still responsible for all charges incurred.

2. Clinic has contractual agreements with many insurance carriers. Some contracts require that we accept payment from the insurance carrier as payment in full, in such cases, Patients may not be responsible for co-payments and deductibles.

3. If insurance carrier fails to remit payment for services within ninety (90) days, the Patient will be billed for the balance on the account. All statements are due in full upon receipt.

4. Clinic does not provide refunds of any monies paid by or on the behalf of patient if the Patient leaves the clinic against medical advice or for major rule violations.

5. If Patient is transferred for therapeutic or medical reasons, any monies paid by or on behalf of the Patient will be refunded less our full per diem rate for each day Patient was at our clinic.

6. Initial payment for treatment is due upon admission unless insurance assignments are accepted. Subsequent payments are due on the first day of each subsequent treatment period.

7. I understand that my records are protected under Federal Confidentiality regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations) published August 10, 1987, and cannot be disclosed without my written consent unless other provided in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS), and/or related

Print Name: ______________________________________ Date: _____________________

Signature: ____

NOTICE TO PATIENT FINANCIAL RESPONSIBILITY

Billing and Insurance

As a courtesy to our patients, Harm Reduction Center will verify your mental health benefits with your insurance carrier. In order to do so, we must obtain a copy of your insurance card and obtain the name, address, and birth date of the subscriber. The information that we receive is not a guarantee of payment. We recommend that you reference your mental health benefit policy or consult your insurance carrier directly with questions regarding benefits and participation. In addition, Harm Reduction Center will bill your insurance carrier for services provided. All co-payment amounts are due at the time of service. Co-insurance, deductibles, and any outstanding balances will be due upon receipt of our billing invoice.

Payment Options

Harm Reduction Center accepts cash, checks, money orders, and major credit cards. Monthly payment plans may be arranged.

Self-Pay

To assist our self-pay patients, Harm Reduction Center has developed a Self-Pay Fee Schedule Discount Program. Designed to help defray the cost of medical care for the uninsured, the program offers a discount to uninsured patients only.

No-Show, Late, & Cancellation Policy

This policy has been established to help us serve you better. It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of healthcare to other patients. "No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

A charge of $50.00 will be assessed for each no show, late arrival, or late cancellation office visit appointment if less than 24 hours' notice is given.

Collections

Harm Reduction Center will make every effort to assist patients with meeting their financial obligations. However, in the event that the patient does not respond to our billing invoices or neglects to make arrangements, we reserve the right to transfer the outstanding balance to a collection agency. We also reserve the right to report delinquent accounts to credit bureaus and charge applicable collection agency fees directly to the patient.

I, __________________________ understand and agree to the above **Financial Responsibilities**. (First, Last Name)

Signature: ______________________________________ Date: _______________________

SURPRISE BILLING PROTECTION FORM

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of network care.

***IMPORTANT**: You are not required to sign this form and should not sign it if you did not have a choice of health care provider before scheduling care. You can choose to ger care from a provider or facility in your health plan's network, which may cost less. If you would like assistance with this document, ask your provider or patient advocate. Take a picture and/or keep a copy of this form for your records.*

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services.

Getting care from this provider or facility will likely cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you. If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ Lisa Margo-Guertin APRN PMHNP, Anjalee Haldane LMHC, Kyle Short LMHC, Leon Melnitsky LCSW

☐ Harm Reduction Center LLC

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on ______________ explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

______________________________ or ______________________________

Patient's signature | Guardian/authorized representative's signature

Print name of patient | Print name of guardian/authorized representative

Date and time of signature | Date and time of signature

Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.