Mind Mechanix, LLC

New Client Registration

This form may be faxed to (302) 725-5942

****Please provide a copy of drivers license and insurance card (both sides)****

Therapist Name: _____

Client Name:

_____

(Last) *(First)* *(Middle Initial)*

Date of Birth: _____ **Gender:** _____ **Social Security #:** _____

Home Address: _____ **Apt #:** _____

_____

(City) *(State)* *(Zip)*

Phone #: _____ **Alt. #:** _____ **Marital Status:** _____

Referring Provider: _____ **Phone #:** _____

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____

Policy Holder's Name: _____ **Date of Birth:** _____

Social Security #: _____ **Client Relationship to insured:** _____

****

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Policy Holder's Name: _____ **Date of Birth:** _____

Social Security #: _____ **Client Relationship to insured:** _____

AUTHORIZATION TO BILL INSURANCE

Client or authorized person's signature: I authorize Practice Solutions, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed: _____ Date: _____

Printed Name: _____

Email: _____

556 S. DuPont Blvd, Ste I, Milford, DE 19963
(T) 302.503.5142 (E) info@mindmechanixllc.com (W) MindMechanixLLC.com

Mind Mechanix, LLC

Client Rights

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the practitioner and client, and the particular issues the client hopes to address. There are many different methods we may use to deal with those issues. Psychotherapy is not like a normal medical doctor visit. Instead, it calls for an active effort on your part as well as ours. In order for the therapy to be the most successful it can be, it is best to work on things we talk about both during our sessions and at during your own time.

Psychotherapy has risks along with its many benefits. Because therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Our initial sessions will involve an evaluation of your needs. By the end of the evaluation, we will offer our impressions of what our work will include and a treatment plan to follow, if you decide to continue with our services. You should evaluate this information along with your own opinions about whether you feel comfortable working with us. At the end of this evaluation, we will notify you if we believe that the clinician is not right for you and, if not, we will give you referrals to other practitioners whom we believe are better suited to help you.

SESSIONS

We generally conduct an initial evaluation that will last from one to two sessions. During this time, we can together decide if we are the best practitioner to provide the services you require in order to meet your treatment goals. If we agree to begin psychotherapy, we will usually schedule one 60-minute session per week. Once an appointment hour is scheduled, you will be charged for it unless you provide 48 hours advance notice of cancellation.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and can only be released with your written permission, subject to exceptions. These exceptions typically include threats to the health and safety of the client him or herself and/or other individuals, or mandated reports of suspected child abuse or neglect. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are complex, and we are not attorneys.

If you are in couples' (relationship) therapy with us, and you and your partner decide to have individual sessions as part of the couples' therapy, the individual sessions will be considered to be a part of the couples' therapy, and can be discussed in our joint sessions. Where applicable, we will remind you of this policy before beginning such individual sessions.

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TREATMENT TERMINATION

Ideally, therapy ends when your treatment goals have been achieved. However, if during the course of your treatment we determine that we cannot continue, we will terminate treatment and provide a written explanation why this is necessary.

As the client, you have the right to end treatment at any time. If you make this choice, referrals to other therapists will be provided and you will be asked to attend a final session. Appropriate referral(s) will be always be offered and available upon request.

Other situations that warrant termination include becoming threatening during session, bringing a weapon onto the premises, persistent drug abuse, arriving under the influence of drugs or alcohol, and/or disclosing illegal intentions or actions.

THIS AGREEMENT MAY BE MODIFIED OR AMENDED AS REQUIRED BY LAW OR IN THE COURSE OF HEALTH CARE OPERATIONS.

BY FOR SIGNING THIS FORM VIA THE SIGNATURE PAGE *(see last page of packet)*, YOU ARE INDICATING THE FOLLOWING:

- YOU HAVE BEEN PROVIDED A COPY OF MIND MECHANIX LLC'S INFORMED CONSENT AND PRIVACY PRACTICES.
- YOU HAVE READ AND UNDERSTAND ALL POLICIES CONTAINED WITHIN THESE DOCUMENTS.
- YOU CONSENT TO AND ACCEPT ALL OF THESE POLICIES AS A CONDITION PRECEDENT TO RECEIVING MENTAL HEALTH SERVICES.

(INFORMED CONSENT)

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Mind Mechanix, LLC

Statement of Client Rights, Responsibilities, Practice Information and Social Media Policy

Client Rights and Responsibilities

Client Rights

You have the right to be treated with dignity and respect.
You have the right to know the qualifications and professional experience of your provider.
You have the right to expect professional and competent help.
You have the right to ask questions about anything related to your treatment.
You have the right to know information concerning diagnosis and treatment philosophy.
You have the right to participate in decisions related to your treatment.
You have the right to request another provider should you not be satisfied with the provider paired with you.
You have the right to end therapy at any time.

Client Responsibilities

You are responsible for taking an active role in the counseling process.
You are responsible for providing information about past and present physical and psychological problems including hospitalizations, medications and previous treatment.
You are responsible for keeping your appointments. We have many clients requesting our services so your reserved time is valuable. Kindly give us 48 hours' notice so that we can fill the spot with someone on the waiting list.
You are responsible for arriving on time for your appointments.

Hours of Operation (by appointment only)

Monday	*9am-9pm*
Tuesday	*9am-9pm*
Wednesday	*9am-9pm*
Thursday	*9am-9pm*
Friday	*9am-5pm*

CONTACTING US

We are often not immediately available by telephone and will not answer the phone when with a client. We do not have dedicated call-in hours. When unavailable, you may leave a message on the confidential voice mail, which is monitored regularly. If you leave a message, please be sure to include times that you are available and a call-back number. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays, unless you specify that it is an emergency. **IN THE EVENT OF AN EMERGENCY, YOU ARE EXPECTED TO CALL 911 OR GO STRAIGHT TO THE NEAREST EMERGENCY ROOM.**

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After Hours Access

If you are calling for a medical emergency, please call 911 immediately. If you have a psychiatric emergency after hours (including weekends and holidays), go to the nearest emergency room or dial 911. If you call the Mind Mechanix, LLC general number, we will return your call when we return to the office. For resources, please see resource list on website (www.mindmechanixllc.com)

Child Priority Response- Crisis Services (24/7)
(800) 969-HELP (4357)

Other resources that can be reached after hours include:

Crisis Intervention Services, Northern Delaware
Herman Holloway Health Campus, 1901 N. DuPont Hwy., Springer Building, New Castle, DE 19720
Staffed 24 hours a day, 7 days a week. Serves all of New Castle County and greater Smyrna in Northern Kent County. Provides phone support, mobile outreach and walk-in crisis services. 302-577-2484 & 800-652-2929.

Crisis Intervention Services, Southern Delaware
700 Main Street (Rear Entrance), Ellendale, DE 19941. Staffed 24 hours a day, 7 days a week. Serves all of Sussex County and Kent County south of greater Smyrna. Provides phone support, mobile outreach and walk-in crisis services. 302-577-2484 & 800-345-6785

Medication Policy

Please note that we do not offer medication management services. Upon request, we will be happy to refer you to a collaborative provider with whom we are associated for evaluation and prescription needs.

Technology and Social Media Policy

Due to potential privacy and confidentiality concerns, communication via unsecured email is strictly prohibited. You will be given credentials to log into the Therapy Notes Portal, which features secure communication options. These are the only messages that we will respond to, and will do so via the portal. Our e-mail boxes are HIPAA compliant; however, your personal email may not be. You may email us anything you would like, but we will only upload documents to the secure portal.
If you communicate confidential or private information via SMS (text), you are thereby assuming the risk that such communication may be intercepted or seen by a third party. Text messages will be read and responded to at our convenience, and there is no guarantee they will be seen or responded to at all, as this is not a preferred method of communication and offered as a convenience feature. If e-mail communication requires an extended response, we will save it for review during your appointment time barring an emergency. Please note that any emails we receive from you and any responses thereto will be uploaded to our secure portal, where they become a part of your record and may be revealed in cases where your records are summoned by a legal entity subject to applicable privacy laws.

SOCIAL MEDIA FRIENDING IS STRICTLY PROHIBITED: If there are things from your online life that you wish to discuss, please bring them into your sessions where we can view and explore them during the therapy period.

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Concerns and Grievances

While you are a client of Mind Mechanix, LLC., we will do our very best to meet and exceed your needs. If you believe we have not met your needs or expectations, we would sincerely like to discuss your concern. Concerns regarding any aspect of Mind Mechanix, LLC. may be submitted either verbally or in writing, by anyone. When filing a grievance, you are encouraged to speak with your provider, any staff member, or administrator at Mind Mechanix, LLC at (302) 313-1288 to address these concerns.

This agreement may be modified or amended as required by law or in the course of health care operations.

BY FOR SIGNING THIS FORM VIA THE SIGNATURE PAGE *(see last page of packet)*, YOU ARE INDICATING THE FOLLOWING:

- YOU HAVE BEEN PROVIDED A COPY OF MIND MECHANIX LLC'S CLIENT RIGHTS AND RESPONSIBILITIES, HOURS OF OPERATION, AFTER HOURS ACCESS, CONTACT PROTOCOLS, MEDICATION POLICY, TECHNOLOGY AND SOCIAL MEDIA POLICY, AND CONCERNS AND GRIEVANCES POLICY.
- YOU HAVE READ AND UNDERSTAND ALL POLICIES CONTAINED WITHIN THIS DOCUMENT.
- YOU CONSENT TO AND ACCEPT ALL OF THESE POLICIES AS A CONDITION PRECEDENT TO RECEIVING MENTAL HEALTH SERVICES.

(Statement of Client Rights, Responsibilities, Practice Information and Social Media Policy)

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Mind Mechanix, LLC

Professional Fees and Financial Policy

Intake Evaluation- $250
60 minute Individual/Family- $200
45 minute Individual/Family- $175
30 minute Individual/Family- $150
60 minute Relationship- $250
Group Session- $75

Court Fees - Please be advised that if you anticipate a court case or are currently involved in a case and will require your therapist's participation there will be a minimum fee of $250.00 per hour. There is a $1500.00 minimum for any in-court appearance, plus preparation ($200.00/hr), phone calls ($200.00/hr), and travel ($0.57/mile + tolls). Any subpoenaed/requested records for legal purposes are NOT a record request and require preparation prior to fulfilling the request at $200.00/hr. There is a two (2) hour minimum for depositions. Mind Mechanix, LLC. requires a 50% deposit within 48 hours of the court date. Time will be rounded up to the nearest tenth- hour. ALL FEES ARE DOUBLED TO LEAVE THE STATE BOUNDARIES OF THE STATE OF DELAWARE.

Non-Legal Letters or Paperwork - Mind Mechanix, LLC. understands that there may be instances when your treatment may require your therapist to write a letter or to complete paperwork. If this should arise, there will be a fee that will be applied to your account. This fee will NOT be billed to your insurance company, as they do not cover these services in coverage. There is a minimum fee of $50 for any typed letter and $10 per page for any paperwork that needs to be completed. These fees will need to be paid in full before you are able to receive the information.

Medical Records - As a courtesy, Mind Mechanix, LLC. will fax or email any authorized medical records to another therapist, physician, or agency as a courtesy for your continuity of treatment. However, if you are requesting a personal copy of your medical records, there will be a $40.00 medical records fee applied to your account. The fee will need to be paid prior to receiving your medical records. Records may be redacted, or refused for release, based on a review of your request by provider and administration.

24 HOUR CANCELLATION/NO SHOW POLICY

APPOINTMENTS POLICY

In order to begin therapy at Mind Mechanix LLC, we require clients to complete a Credit Card Billing Authorization Form. This form allows Mind Mechanix LLC to automatically charge your card for No Shows, and also for cancellations made less than 24-hours from your scheduled appointment. The No Show/Less than 24-Hour Cancellation fee is the FULL amount of your session fee. Exceptions will certainly be made for sudden injury/illness or emergency situations; documentation may be required for fee to be reduced or waived, and will be limited to a one-time courtesy. Occurrences arising from transportation issues, traffic, sudden scheduling conflicts, etc. will not be considered as exceptions. In the event of repeated late cancellations, Mind Mechanix, LLC reserves the right to terminate your treatment with the practice.

For Medicaid/Medicare clients, TWO (2) no show or late cancel appointments will result in referral to another agency. THIS POLICY IS STRICTLY ENFORCED. Telemedicine may be utilized in place of an appointment, if your therapist is agreeable.

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Financial Policy

Outpatient behavioral health coverage is not always as straightforward as other medical specialties. We will do everything in our power to assist you in obtaining your insurance benefits, however, the primary responsibility for this lies with the patient. There are no guarantees implied in our reaching out to your insurance provider for information; this is a courtesy. Any questions with regard to your individual insurance policy must be directed to your carrier.

Payment is due at the time services are rendered. We accept all major credit cards, HSA, money orders and checks. If a check is returned due to insufficient funds, Mind Mechanix, LLC. will charge your account a $35.00 Returned Check Fee and will no longer accept checks from you for payment.

In the event that you are paying for services out-of-pocket/fee-for-service/cash, without a participating insurance carrier, Mind Mechanix LLC utilizes a sliding pay scale. Please speak to the administrator to discuss. Consideration is made on an individual basis, based on ability to pay. Supporting documentation, including but not limited to proof of income, may be required to qualify.

Settling of Balances

There may be times where the insurance company processed a claim in an unexpected manner, potentially leaving a higher out-of-pocket expense than anticipated.

If you have a balance with our office for 90 days or longer, we will send your account to a collection agency. By doing so, we add a 35% collection fee to your account. Once the account is turned over to the collection agency, the balance must be paid in full before you are able to return as a client. We want to work with you on your balance; if you are unable to pay the full balance when due, please contact us as soon as practicable.

Collection Authorization

I understand if I have an unpaid balance to "Mind Mechanix" and do not make satisfactory payment arrangements, my account may be placed with external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for "Mind Mechanix" or their designated external collection agency to service my account and where not prohibited by applicable law, I agree that "Mind Mechanix" and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

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BY FOR SIGNING THIS FORM VIA THE SIGNATURE PAGE *(see last page of packet)*, YOU ARE INDICATING THE FOLLOWING:

- YOU HAVE BEEN PROVIDED A COPY OF MIND MECHANIX LLC'S PROFESSIONAL FEES AND FINANCIAL POLICIES, THAT WE HAVE DISCUSSED THESE POLICIES, AND YOU UNDERSTAND THAT YOU MAY ASK QUESTIONS ABOUT THEM AT ANY TIME IN THE FUTURE
- YOU UNDERSTAND THAT IF YOU HAVE AN UNPAID BALANCE TO MIND MECHANIX LLC AND DO NOT MAKE SATISFACTORY PAYMENT ARRANGEMENTS, YOUR ACCOUNT WILL BE PLACED WITH EXTERNAL COLLECTION AGENCY AND YOU AGREE TO ALL TERMS SET IN THE COLLECTION AUTHORIZATION SECTION ABOVE.
- YOU HAVE READ THIS DOCUMENT IN ITS ENTIRETY AND UNDERSTAND YOUR RIGHTS AS A CLIENT, AND ACCEPT THE RESPONSIBILITY AS STATED.
- YOU CONSENT TO AND ACCEPT ALL OF THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICE

(Professional Fees and Financial Policy)

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Mind Mechanix, LLC

556 S. Dupont Blvd., Suite I
Milford, DE 19963
mindmechanixllc.com
(302)503-5142
info@mindmechanixllc.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ *See pages 3 and 4 for more information on these uses and disclosures*

Notice of Privacy Practices • Page 1

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

To request your medical information, write to MIND MECHANIX, LLC, 556 S. Dupont Blvd., Ste I, Milford *DE 19963. If you request a copy of your record, we reserve the right to charge you for our cost to copy the information, up to $0.50 per page. We will tell you in advance if there will be a charge and what the cost will be. Please allow 20 business days for this request.*

Right to Request Amendment of Medical Information You Believe is Erroneous or Incomplete. If you examine your medical information and believe the information is wrong or incomplete, you may request to amend your medical record. For information about amending your medical record, please contact MIND MECHANIX, LLC, at the address or phone number listed above.

This Notice of Privacy Practices applies to MIND MECHANIX, LLC and all personnel, contractors, volunteers, students, interns, and other trainees. The notice also applies to providers who come to MIND MECHANIX, LLC to care for clients. These providers may include physicians, physician's assistants, nurse practitioners, therapists, and other healthcare providers not employed by MIND MECHANIX, LLC, unless these other providers give you their own notice that describes how they will protect your health information. MIND MECHANIX, LLC may share your medical information with these other healthcare providers for their treatment purposes, to obtain payment for treatment, or to conduct healthcare operations. This arrangement is only for sharing of information and does not create any affiliation with these other providers. Other healthcare providers also have their own Notices of Privacy Practices that apply to their offices and facilities.

Notice of Privacy Practices • Page 4

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 1, 2018

This Notice of Privacy Practices applies to the following organizations.

Mind Mechanix, LLC

BY FOR SIGNING THIS FORM VIA THE SIGNATURE PAGE *(see last page of packet),* **YOU ARE INDICATING THE FOLLOWING:**

- *YOU HAVE BEEN PROVIDED A COPY OF MIND MECHANIX LLC'S PRIVACY PRACTICES.*
- *YOU HAVE READ AND UNDERSTAND ALL POLICIES CONTAINED WITHIN THIS DOCUMENT.*
- *YOU CONSENT TO AND ACCEPT ALL OF THESE POLICIES AS A CONDITION PRECEDENT TO RECEIVING MENTAL HEALTH SERVICES.*

For additional information, comments, or complaints, please contact Justin S. Linefsky at justin@mindmechanixllc.com, or (302) 503-5142.

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Mind Mechanix, LLC

Parent Authorization for Minor's Mental Health Treatment

Custody of Minor and Authorization to Consent

Signing for this authorization of treatment of your child is necessary to move forward with treatment. By signing this authorization, you are certifying that you are legally responsible for medical decisions and have authority to independently consent to treatment without consent from another legal guardian. In addition, you agree to declare and furnish a copy of **any** enforced custody agreements, as soon as possible.

Individual Parent/Guardian Communications

During the course of our treatment of the patient, we may meet with the child's parents/guardians either separately or together to discuss treatment or other circumstances as they may arise. Please be aware that no confidential relationship is created by these meetings absent express notification of the same. Please be aware that at all times the child is our client. We will notate your child's treatment records during these meetings, which will be available to any person or entity that is granted access to your child's treatment record pursuant to relevant privacy laws.

Mandatory Disclosures of Treatment Information

In some situations, we are required by law or by the guidelines of our profession to disclose information, whether or not we have you or your child's permission. Confidentiality cannot be maintained when:

- Child clients are doing or planning things that could cause serious harm to them or someone else, even if they do not intend to harm himself or herself or another person. In these situations, we will need to use our professional judgment to decide whether a parent or guardian, or the proper authorities and/or intended victim should be informed.
- I learn that a child is being neglected or physically, emotionally or sexually abused—currently or at some time in the past. In this situation, we may be required by law to report the alleged abuse to the appropriate state child-protective agency.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the practitioner and the patient. It is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be communicated to others, including their parents.

It is our policy to provide you with general information about your child's treatment, but *not* to share specific information your child has disclosed to us without your child's agreement. This includes activities and behavior that you may be upset by, but that do not put your child at risk of serious and immediate harm in our professional opinion. However, if your child's behavior becomes more serious, then we will use our professional judgment to determine whether your child is in danger. If and only if we feel that your child is in such danger, we will communicate this information to you.

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(T) 302.503.5142 (E) info@mindmechanixllc.com (W) MindMechanixLLC.com

THIS AGREEMENT MAY BE MODIFIED OR AMENDED AS REQUIRED BY LAW OR IN THE COURSE OF HEALTH CARE OPERATIONS.

(Parent Authorization for Minor's Mental Health Treatment)

BY FOR SIGNING THIS FORM VIA THE SIGNATURE PAGE *(see last page of packet)*, YOU ARE INDICATING THE FOLLOWING:

- YOU HAVE THE LEGAL AUTHORITY TO CONSENT FOR YOUR CHILD'S MENTAL HEALTH TREATMENT.
- YOUR AGREEMENT TO RESPECT YOUR CHILD'S PRIVACY.
- YOU HAVE READ THIS DOCUMENT IN ITS ENTIRETY AND UNDERSTAND YOUR RIGHTS AS THE PARENT, YOUR CHILD AS A CLIENT OF THIS PRACTICE, AND ACCEPT THE RESPONSIBILITY AS STATED.
- YOU UNDERSTAND YOU ARE ABLE TO PRINT OUT COPIES OF ALL FORMS OR REQUEST THEY BE PROVIDED TO YOU AT ANY TIME.
- YOU CONSENT TO AND ACCEPT ALL OF THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICE

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Mind Mechanix, LLC

Signature Page

Please <u>INITIAL</u> next to each form below to indicate that you have read, understand, and agree to all policies included in this registration packet.

(<u>INITIAL</u> on Lines Below)

_____ **Informed Consent** (page 2-3)

_____ **Statement of Client Rights, Responsibilities, Practice Information and Social Media Policy** (page 4-6)

_____ **Professional Fees, Financial Policy, and 24 Hour Cancellation/ No Show Policy** (Page 7-9)

_____ **HIPAA Privacy Policy** (Page 10-14)

If applicable:

_____ **Parent Authorization for Minor's Mental Health Treatment** (page 15-16)

- YOU HAVE READ THIS DOCUMENT IN ITS ENTIRETY AND UNDERSTAND ALL INFORMATION CONTAINED WITHIN, INCLUDING YOUR RIGHTS AS CLIENT (OR AS THE PARENT WITH YOUR CHILD, AS A CLIENT OF THIS PRACTICE) AND ACCEPT THE RESPONSIBILITY AS STATED.
- WE HAVE DISCUSSED THESE POLICIES, AND YOU UNDERSTAND THAT YOU MAY ASK QUESTIONS ABOUT THEM AT ANY TIME IN THE FUTURE
- YOU CONSENT TO AND ACCEPT ALL OF THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICE

Client Name: _____ **Date of Birth:** _____

Client Signature (*if over 14 years old*): _____ **Date:** _____

Parent/Legal Guardian Name: _____ **Relationship:** _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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Mind Mechanix, LLC

Mind Mechanix LLC 24 Hour Cancellations/No Show Policy

Regular attendance of therapy appointments is vital to achieving your therapy goals, and a missed appointment delays our work together. We understand that sometimes people simply forget about appointments, or that scheduling conflicts arise unexpectedly; we are all human. However, we also wish to offer the perspective that our therapists do not keep set office hours. Once an appointment is scheduled, they have committed that timeframe specifically to you, and arrange their personal and professional time accordingly. It is also extremely difficult for a therapist to fill a canceled appointment time with less than a 24-hour notice.

Therefore, in order to begin therapy at Mind Mechanix LLC, we require clients to complete a Credit Card Billing Authorization Form. This form allows Mind Mechanix LLC to automatically charge your card for No Shows, and also for cancellations made less than 24-hours from your scheduled appointment.

The No Show/Less than 24-Hour Cancellation fee is the full amount of your session fee.

Exceptions will certainly be made for sudden injury/illness or emergency situations. However, occurrences arising from transportation issues, traffic, sudden scheduling conflicts, etc. will not be considered as exceptions. Furthermore, if you arrive late to an appointment, you will still be expected to pay the full amount of the reimbursed hourly session fee.

Please understand that this policy is not intended as a "punishment" of any kind, but rather its purpose is to encourage clients to make all efforts to attend their scheduled appointments, and also serves as a way for Mind Mechanix LLC to respect the dedication of our therapists.

Our commitment to you is that this policy will be enforced in an ethical manner, and your credit card information will be kept in the strictest means of confidentiality and security.

Acknowledgement:

I have read and understand the **Mind Mechanix LLC 24 Hour Cancellation/No Show Policy**. I agree to enter services with Mind Mechanix LLC under the terms of this policy, and will respect the right for Mind Mechanix to charge my credit card accordingly.

Client/Guardian Name (Print): _____

Client/Guardian Signature: _____

Date _____

Mind Mechanix, LLC

Mind Mechanix LLC Credit Card Authorization Form

Privately Insured/Self-Pay Clients

The undersigned agrees and authorizes Mind Mechanix LLC to charge the credit card indicated below payment of:

A) client's session fee/insurance liability for attended sessions; and
B) client's full session fee in accordance to the 24-Hour Cancellation /No Show Policy should the client No Show for an appointment, or fail to give at a least 24-hour notice of a cancellation.

This authorization does not allow Mind Mechanix LLC to charge the card for any other reason without the expressed consent of the card holder. Payment is due at the time of service so please be prepared to be charged at each session; we do not bill for services.

Mind Mechanix LLC utilizes a secured, HIPAA compliant payment system (Clover, via PNC), which was developed specifically for medical providers.

__Visa __Mastercard ____HSA Card ____Discover ____AmEx ____Other

Credit Card Number: _____

Expiration Date _____/_____ CVV Code (on back of card) _____ Zip _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

I, the undersigned, authorize Mind Mechanix LLC to charge my credit indicated above for regular hourly session fees/insurance liabilities, and in accordance to the 24 Hour Cancellation/No Show Policy should I/the client No Show for an appointment, or fail to give a 24-hour notice of a cancellation.

This authorization will remain in effect while I/the client receives services from Mind Mechanix LLC.

Client/Guardian Name (Print): _____

Client/Guardian Signature: _____

Date _____

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