Meraki Healthcare
COMPASSIONATE COUNSELING SERVICES
3393 E Merlin Drive Suite A, Idaho Falls, ID 83404
Ph: 208 643-5343
Fax: 405-259-0767

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

Financial Policy

PAYMENT OF SERVICES

Thank you for choosing Meraki Healthcare. We ask that you read and sign this form to acknowledge and agree to accept financial responsibility for services rendered by Provider to Client.The providers at Meraki healthcare contract with most major insurance companies, and as a courtesy, we will bill your insurance accordingly. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **For all services rendered to minor clients, the authorizing adult accompanying the client is responsible for payment.**

CLIENT PORTION/BALANCE: You are responsible for payment of deductibles, co-payments, co-insurance, and other fees at the time services are rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from clients can be considered fraud. Any returned checks will be charged an additional $25 to your balance.

ASSIGNMENT and RELEASE: I, (or my dependent) hereby assign my insurance benefits, to be paid directly to Meraki Healthcare. I also authorize Meraki Healthcare to release any information required to process my claims. I certify that I have coverage with my insurance as presented and assign directly to **Meraki Healthcare** all insurance benefits, payable to me for services rendered. I agree to inform the agency if I procure additional insurance coverage for services or if I become in-eligible for any insurance providing services. I acknowledge that the agency is required to first seek payment from other sources as required by rule, regulation, or statute.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. We will forward your claim to the **secondary insurance** (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. **In the event your insurance company sends payment to you, (the client) it should be brought to our office to be applied to your balance.**

COLLECTIONS: You will be sent three notices stating your balance (copays, co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. Along with the third and last notice, you will receive an additional letter stating that if we do not hear from you within 60 days, the account will be referred to our collection agency. You bear complete financial responsibility for any fee(s) incurred. Payment arrangements can be made on a case-by-case basis. Title 48, Chapter 3, section 48-304 Requirements for Extraordinary Collection Action (5) https://legislature.idaho.gov/statutesrules/idstat/Title48/T48CH3/.

NON-COVERED SERVICES: I understand that I am financially responsible for any/all remaining balance that my insurance does NOT cover.

INSUFFICIENT PROOF OF COVERAGE: I understand that if I have arrived at my appointment without sufficient proof of insurance (discrepancy in insurance coverage/invalid insurance card) that ultimately, I am responsible for services rendered at this time and choose to receive them willingly. If I provide sufficient proof of being insured within a timely manner (within 5 Business Days), I understand that I may be reimbursed for payment of today's

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services after my claim has been processed and paid for by the insurance. If I do not provide proof of insurance within a timely manner, I understand that I will be responsible for today's visit in full.

THIRD PARTY AGREEMENT: I understand that if I am over 18 years of age, and if another party (ie. parents, church, business, Etc.) agrees to be financially responsible for services rendered, that I must provide written documentation of our financial agreement in the form of a letter. The letter must contain the payer's contact information (Name, Phone Number, Address, Ward, Stake) as well as the specific payment arrangements.

I agree that I am legally responsible and agree to pay to the Provider for all fees, charges and expenses incurred by the below Client or owed to Meraki Healthcare in connection to Provider providing care to Client. I acknowledge and agree that I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Client.

Client or Responsible Party Signature:_____Date:_____

Client/Guardian Printed Name:_____

Relationship To The Client:_____

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Acknowledgement of Receipt of Privacy Notice:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of our HIPAA Notice of Privacy Practices, as well as read, understand, and agree to the terms included.

Signature:_____Date:_____

Acknowledgement of Receipt of Electronic Communication Policies:

Electronic Communication Policies are included in the Privacy and Policy Practices Document.

How would you like to send/receive electronic communications with Meraki Healthcare?

Check all that apply: ☐ Text ☐ Email ☐ None

By signing below, I certify that the email address and phone number provided to Meraki Healthcare on this form is accurate, and that I accept full responsibility for messages sent to and from the above provided email address/phone number. I completely understand, am well aware and acknowledge that communication over the Internet and/or using any type of email or text protocol may not be encrypted, thus it may not be secure. I agree to hold Meraki Healthcare and other organizations and individuals associated with such communication harmless from any and all claims and liabilities arising from or related to this request to communicate via email and/or text.

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Client/Guardian Printed Name:_____

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Consent to Treatment

I consent to treatment at Meraki Healthcare. My provider will recommend treatment based on their assessment and diagnosis. I understand that I have the right to withdraw from treatment at any point, and that I can ask any questions prior to engaging in services. My provider will support me in creating a treatment plan to address my needs that will include frequency of appointments, expected duration of treatment, and interventions my health care provider recommends as potentially beneficial. An accurate report of my mental health and medical history is essential to creating an appropriate treatment plan.

Please initial each line:

____I understand that there are risks and benefits to participating in mental health treatment. There are no guaranteed outcomes, and my success in treatment is reliant on my personal effort and communication with my provider.

____I understand that if I choose not to engage in services or if I choose to withdraw from treatment, there are also risks. My health care provider is not responsible for my decision to withdraw from treatment. There are other health care providers in the area who are also qualified to meet my needs and I can ask for a referral at any time to another clinic.

____I understand that I can ask for my provider's license number, credentials, certifications, and other work experience details to better understand their qualifications. I further understand that the providers are licensed under their professional boards by the State of Idaho, and that I can file a complaint if I believe I have been treated unprofessionally or unethically.

____I understand that while HIPAA privacy rights will maintain confidentiality for my personal health information, there are circumstances that require my provider to share my personal health information with legal authorities and other medical personnel, including suspicions of child abuse or neglect, elder abuse or neglect, or if I am at serious risk of causing significant harm to myself or others.

____I understand that my appointment time is reserved for me and me alone. If I cannot attend my appointment, I will give 24 hours notice before my scheduled appointment time to allow the provider to fill that time. If I do not give 24 hours notice, I am required to pay a $50.00 late cancellation/no-show fee for therapy appointments and $100 for medical appointments. I understand that **two no shows or late cancellations** can result in being referred to another agency for treatment, being placed on a cancellation waitlist, or only being allowed to schedule one appointment at a time.

____Meraki Healthcare does not provide emergency mental health services. Your provider will not be available after hours. I understand that if I have an emergency at any time, I should go to the nearest emergency room or call 911. I can call the office during regular office hours for urgent concerns and they will be addressed by my provider at the provider's earliest availability.

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____I understand that in order to collect payment, Meraki Healthcare may disclose information as allowed by law to collect payment from third party insurance companies, worker's compensation funds, parents, and other responsible parties.

____There are times when legal proceedings require the release of information based on a judge's court order or subpoena. My provider will make reasonable efforts to avoid disclosures when it is both legal and ethical to do so.

____ I understand that providers do not testify in court as expert witnesses or testify in court. If a provider is served a subpoena to testify in court, the charge for any court related time to make phone calls, write emails or letters, travel to and from court, time spent in court, and any other related expense or time are billed at $400/hour and none of that expense is covered by insurance.

____I understand that I can refuse to sign release of information forms that my provider might request to gather information to better inform my treatment plan. I further understand that my failure to consent to transferring and disclosing medical records can have negative consequences for my treatment plan and my provider's ability to make appropriate recommendations.

____I understand that I can refuse services at any time.

____I understand that it is my responsibility to pay for my services or the services of my minor child. I will keep a credit card on file with the agency, and I understand that my card will be billed the day services are rendered for my balance owed.

By signing this consent to treatment form, I agree that I understand my rights and responsibilities. I also agree that I have been provided with the agency's HIPAA privacy policies for my review.

_____

Client/Guardian Signature Date

_____

Client Signature for those age 14 and older Date

_____

Client/Guardian Printed name Relationship to the client

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Telehealth Consent to Treatment

I understand that like other mental health services, there are benefits and potential drawbacks to engaging in telehealth services. There are some therapeutic elements that might be missed through telecommunication, including a client's emotions and affect due to the nature of technology. While my provider will work to maintain high standards of care, choosing telehealth can impact the therapeutic process.

There are additional security risks associated with telehealth. Meraki Healthcare maintains HIPAA compliant platforms to increase security, but there are other potential breaches, technical issues and failures, and interruptions to services with technology. I understand that to maintain my privacy, I must be using private WI-FI or a smartphone for my appointments.

I understand that the clinician is not responsible for data breaches if a third-party gains access during an appointment. It is my responsibility to be in a secure, private location for my appointment. If it is evident that there is an emergency during my appointment, my provider may choose to call emergency personnel/911 to respond.

I understand that licensing laws require that I be physically present in the State of Idaho at the time of services. I Agree to be in the State of Idaho for all telehealth appointments and for the duration of the appointment.

Understanding the risks and benefits, I consent to treatment through telehealth services.

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Client/Guardian Printed Name:_____

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Credit Card Authorization

By signing this form, you authorize charges to your credit card through Stripe via Simple Practice for services rendered. These charges will appear on your bank/credit card statement as Meraki Healthcare. You have the right to request a paper copy of this document. I agree that it is my responsibility to ensure my insurance information (member number, co-pay, deductible, etc.) is accurate and up-to-date to ensure I am charged accurately. If there is a balance due that I am unable to pay in full, it is my responsibility to contact the billing department at **(208) 643-5343** or nikola@mhidaho.com prior to attending the session to set up a payment plan.

I authorize Meraki Healthcare to charge my credit card through Stripe. I also agree that my credit card can be charged **$50.00** for the first time I NO SHOW OR LATE CANCEL an appointment for counseling without notice to Meraki Healthcare within 24 hours. Additionally, my card can be charged **$100.00** for NO SHOW/ LATE CANCELED counseling appointments after the first no show/late cancel appointment. For Medication Management, I agree that my card can be charged **$100.00** for any appointment that was NO Showed/ Late canceled without notice to Meraki Healthcare within 24 hours. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Meraki Healthcare in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions corresponded to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Responsible Party Signature:_____

Responsible Party Name: _____Date:_____

Is this card an HSA card? Yes _____ No _____

Name on Card:_____

Card Number: _____Expiration Date: _____/_____

CVV Code: _____ Billing Zip Code: _____

By signing below, I am authorizing Meraki Healthcare to automatically charge my credit card for my co-pay, co-insurance or any outstanding balance I may have. I understand automatic payment charges occur daily, charging outstanding balances and current co-pays on all accounts without signed payment agreements. (OPTIONAL)

Signature:_____

Name: _____

You may revoke this permission at any time by contacting our office at (208) 643-5343