THE COASTAL WELLNESS CENTER
PROVIDING HOPE & HEALING ONE PERSON AT A TIME

Patients Bill of Rights

The Association of American Physicians and Surgeons adopted a list of patient freedoms in 1990, which was modified and adopted as a 'patients' bill of rights' in 1995: *All patients should be guaranteed the following freedoms:*

- *To seek consultation with the physician(s) of their choice;*
- *To contract with their physician(s) on mutually agreeable terms;*
- *To be treated confidentially, with access to their records limited to those involved in their care or designated by the patient;*
- *To use their own resources to purchase the care of their choice;*
- *To refuse medical treatment even if it is recommended by their physician(s);*
- *To be informed about their medical condition, the risks and benefits of treatment and appropriate alternatives;*
- *To refuse third-party interference in their medical care, and to be confident that their actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians;*
- *To receive full disclosure of their insurance plan in plain language, including:*

    CONTRACTS: A copy of the contract between the physician and health care plan, and between the patient or employer and the plan;
    INCENTIVES: Whether participating physicians are offered financial incentives to reduce treatment or ration care;
    COST: The full cost of the plan, including copayments, coinsurance, and deductibles;

    COVERAGE: Benefits covered and excluded, including availability and location of 24-hour emergency care;
    QUALIFICATIONS: A roster and qualifications of participating physicians;

    APPROVAL PROCEDURES: Authorization procedures for services, whether doctors need approval of a committee or any other individual, and who decides what is medically necessary;
    REFERRALS: Procedures for consulting a specialist, and who must authorize the referral;

    APPEALS: Grievance procedures for claim or treatment denials;

    GAG RULE: Whether physicians are subject to a gag rule, preventing criticism of the plan.

I have read and understand these patient's rights listed above.

SIGNATURE_____________________________________ **DATE** ____________________

Christopher Canclini MA, LMFT 53907
330 James Way Suite 180, Pismo Beach, CA 93449
CELL: 805.598.0631 FAX: 805.295.6889

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Please list all medications you are currently taking:

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

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MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

Please list all OVER THE COUNTER DRUGS you are currently taking:

(ALCOHOL, CIGARETTES, ASPIRINS, OVER COUNTER DRUGS, NARCOTICS, ETC)

DRUG NAME HOW OFTEN

DRUG NAME HOW OFTEN

Do you have ALLERGIC problems?

Yes No (Please Explain)

SIGNATURE____________________ **DATE** ____________

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CONSENT TO TREATMENT

It is important in beginning our professional relationship to understand both the nature and limitations of the relationship. Please review the following policies to understand these areas:

CONFIDENTIALITY. The therapy relationship is both a professional and confidential relationship protected by professional and ethical standards, to the extent that, with a few important exceptions, what you disclose is confidential and cannot be released without your written consent. However, there are certain circumstances under which we are ethically and/or legally required to disclose information. These include the following:

1. If there is a reasonable belief that child, elder or dependent adult abuse has occurred.
2. If you make a threat to harm a third party and/or you pose a risk to yourself or others.

You should also be aware your confidentiality can be waived if you tender your mental condition in civil or criminal limitation. Thus, the decision of whether to tender your mental condition is an issue you should consult your attorney on.

APPOINTMENTS. Once an appointment is made that time has been reserved solely for you. If you find you are unable to keep your appointment, it is your responsibility to notify us and cancel your appointment at least 24 hours in advance (48 hours is greatly appreciated). Failure to cancel 24 hours in advance will result in a $100 charge (depending on insurance).

PAYMENTS/FEES POLICY. Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Clients who carry insurance should remember professional services are rendered and charged to the patient and not to the insurance company. We will gladly provide you with a receipt, which you can submit to your insurance company for reimbursement and fill out any necessary forms. We accept, cash, credit cards or checks. There is a $40.00 charge for checks with insufficient funds.

COLLECTIONS POLICY. In the event you fail to make reasonable efforts to pay your bill, our office retains the right to pursue delinquent accounts. Our office will make every effort to work out a reasonable payment arrangement should you request that. However, patients who refuse to will have their accounts transferred to our collection agency. If it becomes necessary to transfer your account to our collection agency, your financial records will be released and your delinquent balance will be recorded with TRW. Please be aware we take this action only as a last resort.

TELEPHONE POLICY. Telephone calls are always welcome. Any phone conversation more than a check-in (3 to 5 min) will be billed as a partial (25 min) whole (50 min) session.

I have read the above policies and understand what it says. If I have any questions regarding these policies I will ask my therapist to clarify these policies.

______________________________ ______________
(Client Signature) (Date)

______________________________ ______________
(Therapist) (Date)

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Payment Responsibilities

Charges For Psychotherapy
Your insurance **co-payment is due at the time of service**. If you're insurance does not make a payment **you are responsible for the entire session fee** unless other arrangements are made. If necessary payment arrangements can be arranged that are suitable to both you and the therapist.

Billing For Psychotherapy
As a courtesy this practice will bill your insurance company for you and will notify you if there is a problem with your insurance. **You are responsible for payment of all psychotherapy services provided**. Please note **the Initial Assessment Evaluation may take an hour and a half.**

Insurance Billing

Please verify your insurance coverage before treatment
And obtain pre-authorization for the initial visit

Insurance Companies
Christopher Canclini, LMFT is currently contracted with several insurance panels including, Holman, TriCare, Optim, Blue Cross/Blue Shield of California, Healthnet, Pacificare Behavioral Health, United Behavioral Health, Magellan and American Behavioral. While he is accepting Anthem, Cigna, Aetna, Humana, there is no guarentee these insurance carriers will make a payment. As mentioned above, as a courtesy we will bill your insurance company. **However, you are responsible for payment of all psychotherapy services provided** if the insurance company does not make a payment.

Delays For Your Session Time
At times, minor emergencies may occur or a patient may require additional care during the session before you and a delay may cause the start of your scheduled appointment to start a little late. We value your time and will attempt to remain on schedule. Be assured if the circumstances warrant, you too will receive the same careful attention.

Telephone Billing Policy
Telephone calls are always welcome. Insurance benefits however, do not cover phone calls during or after hours. Therefore, any phone conversation more than a check-in (5-10 min) will be billed as a partial (25 min) or whole (50 min) session depending on the length of the call at $145 a session rate.

Please sign below to indicate notification and agreement with these policies. We will provide you with a copy of this form if you wish.

____ ________________
Patient's signature or signature of guardian Date

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TELEHEALTH PSYCHOTHERAPY CONSENT TO TREATMENT

Dear Client,

It is important in beginning our professional relationship to understand both the nature and limitations of the relationship. Please review the following policies to understand these areas:

CONFIDENTIALITY. The therapy relationship is both a professional and confidential relationship protected by professional and ethical standards, to the extent that, with a few important exceptions, what you disclose is confidential and cannot be released without your written consent. However, there are certain circumstances under which we are ethically and/or legally required to disclose information. These include the following:

1. If there is a reasonable belief that child, elder or dependent adult abuse has occurred.
2. If you make a threat to harm a third party and/or you pose a risk to yourself or others.

You should also be aware your confidentiality can be waived if you tender your mental condition in civil or criminal limitation. Thus, the decision of whether to tender your mental condition is an issue you should consult your attorney on.

APPOINTMENTS. Once an appointment is made that time has been reserved solely for you. If you find you are unable to keep your appointment, it is your responsibility to notify us and cancel your appointment at least 24 hours in advance (48 hours is greatly appreciated). Failure to cancel 24 hours in advance will result in a $85 charge.

PAYMENTS/FEES POLICY. Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Clients who carry insurance should remember professional services are rendered and charged to the patient and not to the insurance company. We will gladly provide you with a receipt, which you can submit to your insurance company for reimbursement and fill out any necessary forms. We accept cash or checks. There is a $40.00 charge for checks with insufficient funds.

COLLECTIONS POLICY. In the event you fail to make reasonable efforts to pay your bill, our office retains the right to pursue delinquent accounts. Our office will make every effort to work out a reasonable payment arrangement should you request that. However, patients who refuse to will have their accounts transferred to our collection agency. If it becomes necessary to transfer your account to our collection agency, your financial records will be released and your delinquent balance will be recorded with TRW. Please be aware we take this action only as a last resort.

BENEFITS AND RISKS OF TELEHEALTH. Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks.

TELEHEALTH IN CASE OF EMERGENCY. If a need for direct, face to face services arises, it is my responsibility to contact practitioners in my area such as through the SB COUNTY ACCESS LINE 1-888-868-1649 SLO COUNTY ACCESS LINE 1-805-838-1381, or to contact my behavioral health practitioner's office for a face to face appointment or my primary care provider if my behavioral health practitioner is unavailable. I understand that an opening may not be immediately available in either office.

1. I may decline any telehealth services at any time without jeopardizing my access to future care, services or benefits.

2. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

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3. In emergencies, in the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means:

   a. In emergency situations: please contact 911 or go to the nearest emergency room or Urgent Care.
   b. Service disruption: please call me at 805-598-0631
   c. For other communication: please email me at chriscanclini@yahoo.com

   I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telehealth consultation. Instead I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

   I have received a copy of my practitioner's contact information, including his/her name, telephone number, business address, mailing address, and email address (if applicable). I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated local contact person in case of an emergency.

4. My practitioner may utilize alternative means of communication in the following circumstances: video connections fail or phone line access is disrupted.

5. My practitioner will respond to communications and routine messages within 48 hours on business days or on the next business day following weekends, holidays, or vacations.

6. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

7. I will take the following precautions to ensure that my communications are directed only to my behavioral health practitioner or other designated individuals: Double check email addresses; double check phone numbers; double check to whom email is sent (reply vs reply all).

8. My communication with my behavioral health practitioner will be stored in the following manner: In compliance with HIPAA regulations in secured file cabinets and/or secured electronic medical record files.

9. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

I have read the above policies and understand what it says. If I have any questions regarding these policies I will ask my therapist to clarify these policies.

Your signature below indicates agreement with its terms and conditions.

Signature	Phone Number	Date
Emergency Contact	Phone Number	Date
Therapist Signature		Date

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Patient Registration

Cell Phone: **Email:**

PATIENT DETAILS					
Legal Name : Last First Middle		Male Female	Married Single	Referred By	
Street	Appt #	City	Zip Code		
Home Telephone #	Social Security	Birth Date	Drivers Lic.#	Expire Yr.	

EMPLOYER			
Homemaker Retired Student	Employer Name	City & Zip Code	Telephone

INSURED AND/OR RESPONSIBLE PARTY				
Legal Name : Last First Middle		Relationship : Parent or Guardian Other _______________ RESPONSIBLE PARTY		
Street Address	Same As Patient	INSURED Insured same as above		
City & Zip Code	Telephone	Social Security	Birth Date	Male Female
Employer Name		Occupation	Telephone	

IN CASE OF AN EMERGENCY			
Name	Relationship	Telephone	Work Telephone

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
Insurance Company Name			Insurance Company Name		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Policy ID #			Policy ID #		
Group #			Group #		
Plan / Program #			Plan / Program #		

Authorization to release information: I agree if the insurance denies or reduces the level of service received I will still be liable for the limiting rate established for treatment I received as submitted to insurance. I hereby authorize my therapist with the Coastal Wellness Center to furnish the insurance company or others authorized by law with full information regarding treatment rendered. I hereby authorize my insurance company to pay directly to my therapist at the Coastal Wellness Center Medical benefits otherwise payable to me. I will be responsible to my therapist at the Coastal Wellness Center for all expenses.

SIGNATURE_________________________________ **DATE** ____________________

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Patient

Thank you for choosing The Coastal Wellness Center. To guarantee the best possible health care, please take time to review the following information and policies. It is very important to us to maintain our good relationship with you, therefore if you have any questions or comments please bring them to our attention.

Thank you!
From the Coastal Wellness Team

Appointment Policies

1. Please contact us at least ***24 hours in advance*** if you are unable to make your appointment. You will avoid a "no show" fee of One Hundred Dollars (**$100.00**) and we can give this time to another patient. If you have two no-shows our therapist-patient relationship will be terminated.

2. If you have a medical emergency, we will try to accommodate your urgent needs. ***Please do not abuse this*** service. If your medical needs are routine, be assured that we will Schedule you ***as*** soon as possible.

3. For emergencies if the office is closed, please contact our regular telephone number (598-0631) and leave a message.

4. Telephone calls are always welcome. Insurance benefits however, do not cover after hours phone calls. Anything more than a check-in phone call (3 to 5 minutes) will therefore be billed as a partial or whole therapeutic hour depending on the length of the call.

Medications

1. For your best care please bring a list of all your medications with you to the office.

Information

1. Please keep us informed of changes in your life - examples would include changes in the following :

Address	Insurance Company
Telephone Number	Employer
Name / Marital Status	Any other important information

This allows us to keep our records current so we can reach you quickly and if necessary and process insurance claims for you efficiently.

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