PALMETTO
COUNSELING & CONSULTING

PCC Consent for Counseling Services

Today's Date_____

Client First Name:_____ **MI:**_____ **Last Name:**_____

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

Ethnicity:_____ **Marital Status**_____

Client Driver's License #:_____ **State Issued:**_____

Client Address:_____ **City**_____ **State**_____ **Zip Code**_____

Home Phone #:_____ **Cell Phone #:**_____ **Work #:**_____

Email:_____ **Ok to leave message?** ☐ **Y** ☐ **N**

Preferred Contact Method for Appointment Reminders: ☐ **Electronic Text** ☐ **Email** ☐ **Telephone Msg**

Legal Guardian (skip if not applicable):

_____**Check if Client is a Minor Legal Custody:** ☐ **Mother** ☐ **Father** ☐ **Joint** ☐ **Other**

Note: If minor, parent / legal guardian(s) must provide PCC copies of the following legal documents if separated, divorced, or legal guardianship:

- Terms of Legal Separation
- Temporary and/or Final Custody & Divorce Decree
- Legal Guardianship

Important Note: *If parent / guardian of minor client is unable to provide PCC copies of legal documentation at time of intake, by signing* ***PCC Consent for Counseling Services consent form****, presenting parent / guardian herby acknowledges you have legal authority to make medical & mental health decisions on behalf of child and further confirms you take financial responsibility for child's treatment independent of any other parent or party's consent.*

_____**Presenting Parent / Guardian Initials**

Emergency Contact List / Family Members involved in Client's Treatment

Emergency Contact Name:_____ **Relationship:**_____

Emergency Contact Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Emergency Contact Phone #:_____ **Email:**_____

PALMETTO
COUNSELING & CONSULTING

Emergency Contact List / Family Members involved in Client's Treatment

Emergency Contact Name:_____ **Relationship:** _____

Emergency Contact Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Emergency Contact Phone #:_____ **Email:**_____

Insurance Policy Holder / Financially Responsible Person Information
[Please Bring Your Insurance Card and Co-pay Fees to Your Appointment]

PRIMARY INSURANCE

First Name:_____ **MI:**_____ **Last Name**:_____

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

Address:_____ **City**:_____

State:____ **Zip code**:_____ **Phone #**:_____ **Email:**_____

Policy Holder's Employer:_____ **Primary Insurance Plan Name**:_____

Insurance ID #:_____ **Insurance Group Policy#**:_____

SECONDARY INSURANCE (SKIP IF NOT APPLICABLE)

First Name:_____ **MI:**_____ **Last Name**:_____

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

Address:_____ **City**:_____

State:____ **Zip code**:_____ **Phone #**:_____ **Email:**_____

Policy Holder's Employer:_____ **Primary Insurance Plan Name**:_____

Insurance ID #:_____ **Insurance Group Policy#**:_____

I understand that I am financially responsible for all deductibles, co-pays and missed appointments, or appointments cancelled without 48-hour advanced notice. I confirm that information I provided is accurate and complete, to the best of my knowledge.
I understand that if I do not inform Palmetto Counseling & Consulting Services, LLC of changes in my insurance coverage before services are rendered, I will be financially responsible for payment in full. I am also responsible for informing Palmetto Counseling & Consulting Services, LLC of any changes in my address, phone number, and emergency contact information.

YOU WILL BE RESPONSIBLE TO FIND A NEW PROVIDER IF YOU FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS WITHOUT PROVIDING 48-HOUR ADVANCED NOTICE.

Assignment of Benefits

I hereby assign, transfer. and set over to Palmetto all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize Palmetto to file (and assign to Palmetto my right to file) my insurance claim under my policy for Palmetto's services. I further authorize the release of any medical information needed to determine benefits, including psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

By my signature, I am consenting to treatment at Palmetto Counseling, and I acknowledge that I have read, understand, and agree to the policies and procedures of counseling services as defined in the PCC Intake Packet I have received.

_____

Client Name [Please Print]

_____

Client Signature Date

_____

Parent / Legal Guardian Signature [If applicable] Date

PALMETTO
COUNSELING & CONSULTING

PCC Intake Forms Packet [Client Copy]

IMPORTANT: TO SECURE YOUR INITIAL APPOINTMENT AND ENSURE YOU HAVE MAXIMUM TIME WITH YOUR THERAPIST (AND MINIMIZE TIME FILLING OUT REGISTRATION PAPERWORK), CLIENT MUST COMPLETE PAGES 1 – 3, & 13 USING EITHER OF THE FOLLOWING::

1. **VISIT WWW.PCCRH.COM TO COMPLETE PAGES 1 – 3, & 13 AND SUBMIT PDF ELECTRONIC SIGNATURE VERSION OF PCC INTAKE FORMS.**

2. **VISIT WWW.PCCRH.COM TO COMPLETE A FILLABLE PDF VERSION OF PCC INTAKE FORMS. PLEASE COMPLETE PAGES 1 – 3, & 13 AND ARRIVE AT LEAST 30 MINUTES BEFORE SCHEDULED APPOINTMENT TIME WITH COMPLETED FORMS, A VALID DRIVERS LICENSE, AND A CURRENT COPY OF YOUR INSURANCE CARD.**

PLEASE NOTE: FAILURE TO DO THE ABOVE MAY RESULT IN YOUR APPOINTMENT BEING CANCELLED OR RESCHEDULED.

These policies and procedures include:

Assignment of Benefits
Palmetto Counseling Financial Policy
No-Show / Cancellation Policy
Member / Client's Rights
PCC Consent for E-Mail and Electronic Means of Communication Clinical
Emergencies / After-Hours Line
PCC Telehealth Informed Consent & Addendum A
Notice Regarding Patient Protections Against Surprise Billing / 'Good Faith Estimate'
Informed Consent
Receipt and Acknowledgment of HIPAA Notice of Privacy Practices
Available at: *https://www.pccrh.com/wpcontent/uploads/2018/11/Palmetto_Counseling_Privacy_Practices.pdf or* hardcopy by request.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Palmetto all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize Palmetto to file (and assign to Palmetto my right to file) my insurance claim under my policy for Palmetto's services. I further authorize the release of any medical information needed to determine benefits, including mental health, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

PALMETTO COUNSELING FINANCIAL POLICY

First Appointment: Please arrive for your initial appointment 30 minutes early so that all paperwork may be completed before you see the clinician. Please bring your current insurance card with you for EACH VISIT. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up to date. Please be prepared to pay for the current visit as well as any past due balance on your account. Payment of co-pay, deductibles or any non-covered services will be required at the time of service. Paying applicable co-pays/deductibles/co-insurance charges at the time of service does not mean that you will not receive a bill after your visit, fees are only estimated. For your convenience, we accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT.

Insurance: When scheduling an appointment at our practice, it is your responsibility to confirm with your insurance company that the clinician is under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral in hand at the time of your appointment. If your insurance should happen to change, we require that you notify our office 48 hours prior to your appointment time. If you do not notify us (before the date services are rendered) of any changes in your insurance coverage, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

PROOF OF INSURANCE. CLIENT MUST PROVIDE CORRECT INSURANCE INFORMATION AT TIME OF SERVICE. FAILURE TO DO SO MAY RESULT IN A $10 REBILLING CHARGE.

CO-PAYS: CO-PAYS ARE DUE AT THE TIME OF SERVICE. A $10 BILLING CHARGE MAY BE ADDED TO COVER BILLING EXPENSES IF NOT PAID AT THE TIME OF SERVICE.

Client is responsible for knowing their benefit coverage for specialist visits. We will be happy to file your insurance claim on your behalf. We allow 45 days from the date the claim was filed for your insurance company to pay. If your insurance does **NOT** pay within this time, you may be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and /or policy benefit criteria (e.g., deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions, or reasonable and customary charges, etc.) other than to supply factual information when necessary.

Out-of-Network Insurance & Insurance Denials: If you have insurance our practice does not accept or a claim is denied by your insurance company, you will be responsible for the full amount of all professional fees and charges for services provided. We can provide you with a receipt for clinical services rendered that you may submit to your insurance company for reimbursement.

If you are insured by a managed care organization (HMO), and being seen for any covered service, you must have PRIOR AUTHORIZATION**.** If you do not obtain authorization, you will be responsible for PAYMENT IN FULL. We recommend you contact the customer service number on your insurance card prior to your first visit to determine if prior authorization is required and basic information regarding your behavioral health benefits.

Any Preferred Provider (PPO) or In-Network discounts will not apply UNLESS YOU HAVE YOUR INSURANCE CARD WITH YOU**.** If you do not have your insurance card with you, insurance has instructed us to collect payment in full for all services

received. If your insurance informs us your eligibility status has changed, you will be responsible for payment in full until verification of insurance benefits is obtained from your insurance carrier.

Usual and Customary Rates: Palmetto is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

You are responsible for deductibles, co-insurance, non-covered services, and any other charges your insurance may not cover. You will be sent monthly statements regarding any monies owed by you, the client. If the same balance becomes more than 3 months past due, you will be charged a finance charge of $10.00 each month thereafter until the balance is paid in full. If your account must be turned over to a collection agency, all discounts will be removed, and collection processing fees will be added to the account. Additional fees may be added if the account is not paid within 45 days of being placed in collections. Credit bureaus are advised of unpaid debt.

Collections: Accounts will be sent to collections after 90 days if not paid as agreed. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you.
You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim]. An administrative fee of **$42** will be applied for **all returned checks with insufficient funds.**

NO SHOW / LATE CANCELLATION POLICY:
Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place and have no way of recovering lost revenue due to "no-shows" or last-minute cancellations.

Palmetto charges a *$70 administrative fee for missed appointments or appointments cancelled or rescheduled with less than 48 hours advance notice *(*Note: excludes the following: TriCare East, SC Medicaid, or in the case of severe illness and life-threatening emergency situations).* This fee is non-refundable and is **not** covered by your insurance or EAP.

I UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW THERAPIST IF I FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS or MULTIPLE NO SHOWS, WITHOUT PROVIDING A **48-HOUR NOTICE**. WE WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS. I HAVE READ AND AGREE TO THE ABOVE POLICY TERMS.

Administrative Fees: Like other medical practices, declining insurance reimbursements and rising costs force us to charge for certain administrative services that are not covered by insurance. The following fees are applicable to all clients and are **not covered by insurance or EAPs** in which client shall be solely responsible:

REVIEW OF PSYCHOLOGICAL / MEDICAL FORMS / LEGAL FORMS / COURT DOCUMENTS / REPORTS, & LETTER COMPLETION (COMPLETED OUTSIDE OF APPOINTMENT TIMES)

- $50 minimum [pro-rated at $25/15 minutes to complete thereafter]

NON-CRISIS TELEPHONE CONSULT / AFTER-HOURS CONSULT WITH CLINICIAN

- $50 minimum [Pro-Rated at $25/15 minutes thereafter]

E-MAIL CONSULT WITH CLINICIAN

□

- $50 minimum [pro-rated at $25 / 15 minutes to complete thereafter]

COURT APPEARANCE / COURT TESTIMONY

- $300 / HOUR

***Note: this fee will apply for each hour clinician is required to be present and not specific to time spent providing testimony**

Thank you for understanding the reason behind these fees. We will be reasonable in applying them and notify you when they apply.

CLIENT RIGHTS ANDRESPONSIBILITIES

Provider acknowledges Palmetto's responsibility to treat clients in a manner that respects their rights, as well as Palmetto's expectations of client's responsibilities, as follows:

- Clients have a right to receive information about their services and providers, clinical guidelines, and Clients ' rights and responsibilities;
- Clients have a right to be treated with respect and recognition of their dignity and need for privacy;
- Clients have a right to participate with Provider in decision making regarding their Treatment Plan and any other aspects of their treatment planning;
- Clients have a right to voice complaints or appeals about their care;
- Clients have a responsibility to provide, to the extent possible, information that the Provider needs to care for them;
- Each Client has a responsibility to follow the Treatment Plan and instructions for care that the Client has agreed upon with Provider; and
- Clients have a responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing mutually agreed upon treatment goals.

CONSENT FOR E-MAIL, ELECTRONIC TEXT, AND OTHER ELECTRONIC MEANS OF COMMUNICATION

As a covered entity under the HIPAA Privacy and Security Rules, we take your privacy and right for confidentiality seriously. Although convenient, email, electronic text, and other forms of electronic communication are not a secure medium because third parties can view and store confidential information. Therefore, email, electronic texts, and other forms of electronic communication are *not* to be considered completely confidential forms of communication, and using email or other electronic methods runs the risk of breaching your confidentiality.

RISKS OF USING E-MAIL , ELECTRONIC TEXT, & OTHER FORMS OF ELECTRONIC COMMUNICATION TO COMMUNICATE WITH PALMETTO COUNSELING

Transmitting client information by e-mail or other electronic methods has a number of risks that need to be considered before using these mediums to communicate with your therapist. These include, but are not limited to, the following risks:

- Electronic communication can be circulated, forwarded, and stored in numerous paper and electronic files.
- Electronic communication can be immediately broadcast worldwide and be received by unintended recipients.
- Electronic communication senders can easily type in the wrong address or phone number.
- Electronic communication is easier to falsify than handwritten or signed documents.
- Backup copies electronic communication may exist even after the sender or recipient has deleted their copy.
- Employers and on-line services have a right to archive & inspect electronic communication transmitted through their network servers.

- Electronic communication can be intercepted, altered, forwarded, or used without authorization or detection.
- Electronic communication can be used to introduce viruses into computer systems.
- Electronic communication can be used as evidence in court.

TYPES OF PERMISSIBLE E-MAIL OR ELECTRONIC COMMUNICATION THAT CLIENT AGREES TO SEND AND/OR RECEIVE includes:

Appointment scheduling requests, appointment reminders, billing and insurance questions, and patient education. Use of electronic communication for general client information only

Clinical Emergencies / After-Hours Line

If you are an active client of Palmetto Counseling and experiencing an urgent, clinical emergency and the office is closed, you may reach the **on-call therapist at (803) 517-3880.** Please leave your name, telephone number and a brief message so that the on-call clinician can assist you. For all other **non-urgent concerns, please contact the office at (803) 329-9639**. Our office hours are 8 am – 5 pm, Monday through Friday or please leave us a voice mail message.

If you feel that you have a **life-threatening emergency, call 911, or go to the nearest emergency room**. In addition, contact the **National Suicide Prevention Hotline # 988, 1-800-273-8255 or 1-800-784 2433** to be connected to a skilled, trained counselor at a crisis center 24/7.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT I acknowledge that Palmetto's therapists and practice administrative staff will not accept friend or contact requests from current or former client's social networking site (e.g., Facebook, LinkedIn, etc.). I understand that adding current or former counselors or practice administrative staff as friends or contacts can compromise my confidentiality and respective privacy.

I have had the opportunity to discuss the above and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail, electronic text, and other forms of electronic communication between the therapist and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the therapist may impose to communicate with clients by e-mail or other electronic methods. Any questions I may have had were answered.

PCC TELEHEALTH INFORMED CONSENT

Introduction of Telehealth:

As a client or patient receiving services at Palmetto Counseling & Consulting Services, LLC through telehealth technologies, I understand:

IMPORTANT: To receive Telehealth services at PCC, client must have a valid, credit card on-file to pay for all applicable copay/session fees [note: credit card information is securely stored with PCC's credit card processor via PCI-compliant, encrypted vault] or Client must Pre-Pay for all applicable copay/fees prior to Telehealth session.

Telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video, or other electronic communications) between a practitioner and a client who are not in the same physical location.

Software Security Protocols:

Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

This service is provided by technology (including but not limited to video, phone, text, apps, and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

You will need access to, and familiarity with, the appropriate technology to participate in the service provided.

Risks of Technology:

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.

Emergency Protocol:

In the event of disruption of service or emergencies, or for routine or administrative reasons, it may be necessary to communicate by other means such as conducting session by telephone.

Client's Electronic Medical Record. Laws & Standards:

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.

ADDENDUM A – ELECTRONIC TRANSMISSION OF INFORMATION:

I, the undersigned, agree to participate in technology-based consultation and other healthcare-related information exchanges with Palmetto Counseling & Consulting Services, LLC, a behavioral health care provider ("provider"). This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named provider, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

It may also mean that my private health information may be transmitted from my provider's mobile device to my own or from my device to that of my provider via an application" (abbreviated as "app").

I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Electronic Presence:

In brief, I understand that my provider will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter an "app" will be transmitted electronically to and from myself and my provider.

Limitations:

Regardless of the sophistication of today's technology, some information my provider would ordinarily get in an in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my provider to understand my problems and to help me get better. My provider will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

I understand that telehealth is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, including some that are not yet recognized.

Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting provider.

Release of Information:

I authorize the release of any information pertaining to me determined by my provider, my other health care providers or by my insurance carrier to be relevant to the consultation(s)or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care providers.

I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.

Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:

I also understand that, under the law, and regardless of what form of communication I use in working with my provider, my provider may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives:

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telehealth consultation's effectiveness.

Records:

I understand that my telehealth consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law.

I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.
I also understand, however, that if my provider, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs.

I hereby authorize these disclosures to take place without prior written consent.

Emergency Care:

I acknowledge, however, that if I am facing or if I think I may be facing an emergency 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.

Release of Liability:

I unconditionally release and discharge Palmetto Counseling & Consulting Services, LLC, its affiliates, agents, employees; and my provider and his or her designees from any liability in connection with my participation in remote telehealth consultation(s).

Final Agreement:

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telehealth consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Notice Regarding Patient Protections Against Surprise Billing

What is 'Balance Billing' (sometimes called 'Surprise Billing')?

When you see a therapist or health care provider, you may owe certain out-of-pocket costs, such as copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

'Out-of-network' describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called 'balanced billing.' This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

'Surprise billing' is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

1. Emergency Services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as co-payments and coinsurance). You can't be balanced billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
2. Certain services at an in-network hospital or ambulatory surgical center

   When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

   If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

   You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the co-payments, co-insurance, and deductibles that you would pay if the provider or facility was in-network). Provided you have completed an assignment of

benefits, your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health and Human Services regarding enforcement of federal balance or surprise billing protection and the South Carolina Department of Insurance regarding enforcement of South Carolina billing or surprise billing protection laws (Phone: 803-737-6160; Address: 1201 Main Street, Suite 1000, Columbia, SC 29201).

Visit www.hhs.gov for more information about your rights under federal law.

Visit www.doisc.gov for more information about your rights under South Carolina law.

You have the right to receive a 'Good Faith Estimate' explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- Upon request, you have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing before your medical services or item. Upon request, you can also ask your health care provider, or any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate or the dispute process visit www.cms.gov/nosurprises, email federalppdrquestions@cms.hhs.gov or call 1-800-985-3059

Disclaimer:

The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date of the original bill.

If you dispute your bill, the provider cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already been moved into collection, the provider has to cease collection efforts. The provider must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider cannot take or threaten to take any retributive action against you for disputing your bill. There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

Receipt and Acknowledgment of HIPAA Notice of Privacy Practices
Available at: *https://www.pccrh.com/wpcontent/uploads/2018/11/Palmetto_Counseling_Privacy_Practices.pdf or* hardcopy by request.

Informed Consent

This agreement supplements the general informed consent and initial intake paperwork that we agreed to at the start of our work together.

I understand that I am financially responsible for all deductibles, co-pays, and missed appointments, or appointments canceled without 48 hours advance notice.

I confirm that the information I provided is accurate and complete, to the best of my knowledge.

I understand that if I do not inform Palmetto Counseling & Consulting Services, LLC of changes in my insurance coverage before services are rendered, I will be financially responsible for payment in full. I am also responsible for informing Palmetto Counseling & Consulting Services, LLC of any changes to my address, phone number, and emergency contact information.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

By my signature, I am consenting to treatment at Palmetto Counseling, and I acknowledge that I have read, understand, and agree to the policies and procedures of counseling services as defined in the PCC Intake Packet I have received.

_____ _____

Signature Date