Premier Counseling Referral Checklist

Prior to starting services with a patient, we must receive the following information:

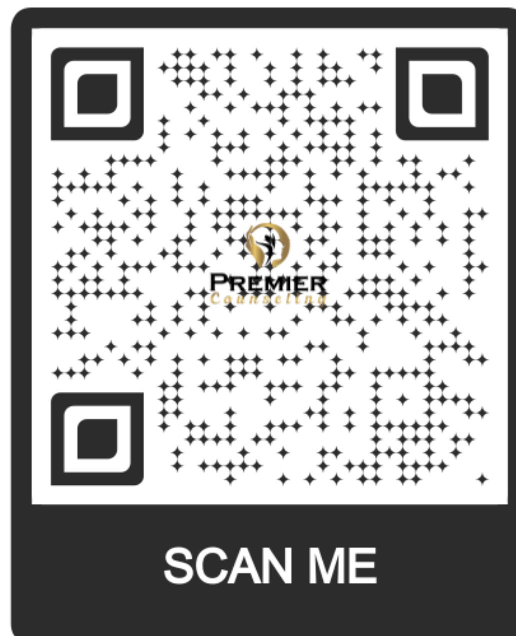
☐ Referral Form

☐ Consent Form

☐ Copayment Waiver Form

☐ Copy of Insurance Card(s), Identification Card, and Social Security Card

(Additional information may be requested. Thanks for your cooperation.)



Patient Referral Form

Referral Guidelines

1. To refer a potential patient, please complete this form and return it, along with a copy of the potential patient's identification card, insurance cards, and social security card (if available)

2. If Patient has a power of attorney, please notify power of attorney of the referral.

3. Referrals can be emailed to info@premiercounselingllc.org or faxed to 864-751-5834. Please include a contact number or email address to allow Premier Counseling to follow-up regarding the receipt of the referral.

Patient Demographic Information

Patient Name: ______________________________ **DOB:** ______________________________

SSN: ______________________________ **Address:** ______________________________

Ins & Policy #. ______________________________ ______________________________

(Please include a copy of cards) ______________________________

Referral Information

Reason for referral: ____

____

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____

Patient Contact Number: ___________________________

Patient or POA Email: ____

POA Contact Number (if applicable): ____________________________

Referral Source Information

Date of Referral: ______________________________ **Patient Aware**: YES/NO ______________________________

Referring Person: ______________________________ **Contact:** ______________________________

Premier Counseling, LLC
4711 Forest Dr. Ste 3 #291
Columbia, SC 29206
803-821-8333
(Revised 11/3/2020)

Confidentiality

The law protects the privacy of all communications between a client and a counselor. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA. The Following are EXCEPTIONS to this principle of confidentiality.

- If you are involved in a court proceeding and a request is made for information concerning the professional services that we provided you, such information is protected by the counselor-client privilege law. We cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend Premier Counseling, LLC.

- Utilizing your insurance requires us to provide diagnostic and treatment information to your insurance company and/or your managed care company.

- If we have cause to suspect that a child under 18 is abused or neglected (PAST or PRESENT), or if we have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that we file a report with the Count Department of Social Services.

- If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim and/or calling the police.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Insurance Reimbursement and Payments

I have been informed, understand, and acknowledge that Premier Counseling, LLC may use confidential information about me to file insurance claims for billing purposes, and to bill and be paid for services. I hereby consent to Premier Counseling, LLC to release information to my insurance company, and/or an outside bulling company for billing purposes.

Provider Choice Agreement

I have received information regarding services which I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based upon this information, I have made an informed choice of the services and providers. I understand that by completing and signing this form, I choose, Premier Counseling, LLC as my service provider (service specified below):

☑ Outpatient Treatment Services ☑ Psychotropic Medication Management ☑ Clinical Assessment

Consent for Treatment

My signature certifies that I consent to treatment with Premier Counseling, LLC. Additionally, I agree to abide by the office policies, practices and procedures and I agree to pay the fees as indicated on previous page of this document. My signature certifies that IF I am prescribed neuroleptic medications (anti-psychotics), I understand that these medicines may help me think more clearly, feel less aggressive and hostile, and may decrease other psychiatric symptoms. Some of them may help my mood. If I take these medications regularly and responsibility (follow directions as given by the medical professional who prescribed the medications) they may keep many of my symptoms from coming back. The medical staff cannot guarantee how I will respond to any of these medicines. My medical professional (Doctor, Nurse Practitioner, Physician Assistant) and I also talked about the side effects that may be related to the use of these medications. I have been told that while taking neuroleptic medication(s) I may have to be monitored for these side effects, including blood testing. My medical professional and I have talked about different treatments for my symptoms and agree to work together if we need to change the dose of my medicine, switch from one medicine to another, or stop my treatment. I agree to take these medicines as prescribed by my medical professional for the treatment of my medical condition. My signature certifies that I consent to being treated via Tele-Health services if the event arises. Services are still required to HIPPA Privacy Standards and will be done over a secure connection. My signature also serves as an acknowledgement that I have been given an opportunity to read a copy of Premier Counseling, LLC's Notice of Privacy Practices.

____ Date: ________________

Client/POA /Guardian Signature

Premier Counseling, LLC
4711 Forest Dr., Ste. – 3, #291
Columbia, SC 29206
(803) 821-8333

Copayment Waiver Form

Patient Name: ____________________________________

Please choose one of the following options:

☐ I am the patient and completing this form for myself

☐ I am the power of attorney for the patient and will complete this form

☐ I am an assisted living staff member aware of patient's income and I am completing the form on the behalf of the patient.

Patient understands that the primary insurance provider only covers a portion of mental health services. Patient is aware that the primary insurance provider expects Patient to pay any remaining balances for mental health services if Patient does not have supplemental insurance to cover the fees. At this time, Patient is requesting a copayment waiver for services due to the financial hardship(s) indicated below:

Please choose all applicable options:

☐ I have a supplement insurance plan therefore I am not in need of a copayment waiver.

☐ I have both Medicare and Medicaid insurance coverage.

☐ I reside in an assisted living setting where the monthly charges are 80% or more of my monthly income.

☐ I reside in an assisted living setting and I am uncertain if my financial resources are enough to cover my expenses for the remainder of my life.

☐ My income is fixed, and I am unemployed at this time. My expenses are 80% or more of my monthly income.

☐ I currently have no monthly income.

My signature (representative's signature) indicates that I have completed this form honestly. If it is discovered I was not truthful in this request I am aware that I will then be responsible for all future copayments.

Patient Signature: ____

Power of Attorney Signature: _________________________________

Assisted Living Representative Signature: __________________________

Consent & Statement of Understanding: Audio/Visual Sessions

Patient Name ____

I hereby authorize Premier Counseling, LLC and its associates to use Doxy.me telehealth platform (or another HIPAA compliant platform) as a means for psychotherapy. Doxy.me is a HIPAA compliant platform for telecommunication.

I am aware that Premier Counseling, LLC will provide, if needed, a behavioral health technician/telehealth assistant to assist and support me in-person throughout all telehealth appointments at a no additional cost to me.

I further attest that since I have chosen this form of communication, I am aware that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication. I have been informed that Premier Counseling, LLC will do its due diligence to verify that the service is covered by my insurance prior to the start of treatment and inform me if my insurance does not cover the service.

I understand that I may revoke this authorization at any time by giving written notice. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated if I am not actively participating in ongoing treatment with Premier Counseling, LLC at that time.

____ ________________________
Client's signature (if own responsible party) Date

____ ________________________
Guardian/Power of Attorney Date