Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

Clinical Director: Bradley T. Kinder, M.S., LPC, CSAC
Licensed Professional Counselor, Certified Substance Abuse Counselor

WELCOME

Healing Waters Counseling Center, LLC is an outpatient mental health private practice that was established in May 2010. Outpatient mental health services (including counseling and psychiatric services) are provided in a warm, confidential, and professional environment. For additional information, please visit: www.healingwaterscc.com

OFFICE LOCATIONS

Healing Waters Counseling Center has four service locations:

Cedar Bluff (1113 Cedar Valley Drive, Cedar Bluff, VA 24609)

Wytheville (510 West Main Street, Wytheville, VA 24382)

Wise (106 Spring Avenue Northeast, Wise, VA 24293)

Abingdon (112 East Main Street, Abingdon, VA 24210)

OFFICE HOURS

All offices of Healing Waters Counseling Center are open from 8:30a.m. until 5:00p.m. Monday through Friday unless otherwise indicated. Offices are closed for lunch from 12:00 noon until 1:00pm.

CLINICAL SERVICES

Services are provided by Licensed Professional Counselors, Licensed Clinical Social Workers, Psychiatric Mental Health Nurse Practitioners, Supervisees in Social Work, Residents in Counseling, and/or Residents in Marriage and Family Therapy.

FEES AND PAYMENTS

Information regarding our fee schedule, insurance, and payments is attached. All financial arrangements are made through the office manager (276-963-0111).

MISSED APPOINTMENTS

Information regarding missed appointments is attached.

INCLEMENT WEATHER

Attempts will be made to personally notify individuals with scheduled appointments if the office must be closed due to inclement weather. This may not always be possible. Closing due to weather conditions will be announced on the Healing Waters Counseling Center Facebook page.

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FEE SCHEDULE

Diagnostic Interview (Clinical Assessment)	$140.00
Individual Therapy	$100.00
Family Therapy	$115.00
Group Therapy	$45.00 per person per group session
Psychological Evaluation	$700.00
Record Requests	$10.00 retrieval fee and $0.50 per page
Forms for Disability Claims *(Other than Social Security)	$20.00 per form
Subpoena (court-half day)	$500.00
Subpoena (court-full day)	$1000.00
Minimal phone consultation or correspondence	no charge
Extensive phone consultation or correspondence more than 15 minutes	$50.00 per hour
Missed appointment- hourly rate (Therapy)	$50.00
Missed appointment-hourly rate (Psychiatry)	$70.00

Insurance will not reimburse for review of records, extensive phone consultation or missed appointments. The client or guardian is responsible for those charges.

NOTICE: 24 hours prior notification is required for cancellation of any appointment with Healing Waters Counseling Center, LLC. Missed appointment fees shall be due and payable upon receipt of the invoice for the same. Failure to pay the missed appointment fee, deductible, co-pay, or other amount due may result in referral of your account for outside collection at which time you will also be responsible for any fee amounts due and owing as well as all collection costs, including but not limited to, court costs, filing fees, service fees, and reasonable attorney's fees.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

Healing Waters Counseling Center, LLC has been and will always be totally committed to maintaining the confidentiality of clients. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Virginia State Law, we are obligated to report this to the Department of Social Services. If you provide information that informs us that you are in danger of harming yourself or others, we are obligated to report this. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

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Thank you for choosing Healing Waters Counseling Center, LLC. In order to serve you properly, we will need the following information. (Please print). All information will be strictly confidential.

Patient Name: ______________________________ Today's Date: ________________
Address: ______________________________ Referred By: ________________
City:________________State:_______Zip:___________ Phone: ________________
Email:______________________________ Cell: ______________________
Is the patient in foster care? ☐ Yes ☐ No If so, list name of foster care worker: ___________
Has the patient been seen at **Healing Waters** before? ☐ Yes ☐ No If yes, when? __________

Sex:_______ Age:______ Marital Status:______________ Date of Birth: __________

Occupation:______________________ Patient's Social Security #: ________________
Education:______________________Rate your health: ☐ Excellent ☐ Good ☐ Poor
Do you feel you are a danger to yourself or anyone else right now? ☐ Yes ☐ No
Briefly describe your reason for seeking help: ________________________________
____
List any medications you are now taking and dosages: ___________________________
____
Have you been in counseling/therapy before? If yes, when and for what reason(s)? __________
____

Employer/School
Address, City, State, Zip, Phone
____
____
____

Are you seeking services for the purposes of filing a disability claim? ☐ Yes ☐ No

Employee Type:
Retired ☐
Employed Full Time ☐
Employed Part Time ☐
Not Employed ☐

Student Type:
Student, Full Time ☐
Student, Part Time ☐

Insurance Information: (Please complete thoroughly)

Insured:________________________ Sex:________ Date of Birth: __________
Relationship to patient:________________________SSN:________________
Address of Insured if different from patient:________________________________
Policy Number:________________________ Group Number: ________________
Authorization Number: ____
Employer:____________________Employer's Address: ________________________

Please sign and date the release/assignment below:
I authorize release of any information necessary to process my insurance claims and assign and request payment directly to this Provider.

________________________ ______________

Client (18 or over) or Guardian Date

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CANCELLATION/NO-SHOW POLICY, NOTICE, AND AUTHORIZATION TO BILL CREDIT CARD

EXPLANATION: Healing Waters Counseling Center, LLC, is a very busy counseling practice and appointment openings are very important to our patients. In an effort to deliver only the highest quality services in the most efficient way possible, it has become necessary to implementour "NO-SHOW" Policy. This policy is not designed to penalize, but to ensure that we can makethe best use of all staffing resources and deliver quality, timely services to our clients.

POLICY: All patients of Healing Waters Counseling Center, LLC, must notify the practice of cancellation a minimum of twenty-four (24) hours prior to any scheduled appointment. This notification can be done via telephone to our main office line at **(276) 963-0111**.
Failure to provide the mandatory minimum twenty-four (24) hour notice of cancellation shall result in automatic billing to the client's credit card. This fee shall be designated as a "No-Show Fee." This fee is charged to the patient, not the insurance company. If the cancellation fee cannot be billed to the credit/debit card on file, then it will be due at the time of the patient's next office visit

Fees billed shall be as follows: 1.) Therapist Appointment: $50.00; 2.) Psychiatric Mental Health Nurse Practitioner Appointment: $70.00.

Patients with two No Show visits may receive a letter with a copy of this policy. If there is an additional "No Show" we may not be able to schedule further appointments. We do realize circumstances can change at the last minute. If you were unable to make a scheduled appointment due to extenuating circumstances, please contact our Practice Manager immediately.

AUTHORIZATION: By my signature hereon, I do hereby acknowledge the above policy of Healing Waters Counseling Center and I do further authorize billing of the requisite fee for failure to notify the practice of cancellation within the required timeframe.

I have read and understand this policy. I have had an opportunity to ask questions, which have been addressed to my satisfaction. I understand that failure to comply with the 24 hour notice required by the cancellation policy will result in automatic charges to my credit card and I specifically authorize the charges.

Name:	*Signature:*

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MEDICAL RECORDS REQUEST FEE

Patient Name:____Patient DOB: ________________

The office of Healing Waters Counseling Center, LLC will provide your records to you once you have completed the Authorization for Disclosure/Exchange of Information form. You can find this form on our website or you can contact our office.

Your request will be processed and fulfilled within 30 business/working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20:	**$15.00**
Pages 21-50:	**$25.00**
Pages 51+	**$40.00**

FORM AND LETTER FEE

This is to notify you that the office of Healing Waters Counseling Center, LLC will apply a fee of $20.00 to your account for patient, companies, family members, insurance carriers or other person requesting forms and/or letters to be completed (unless the requesting entity pays for the records request).

Forms include, but are not limited to FMLA, disability, motor vehicle division, continuation of pay, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, etc.

In order to comply with federal laws including HIPAA, as well as, Virginia state and federal statues, this office must have a signed authorization (Authorization for Disclosure/Exchange of Information form) from the patient/responsible party stating who we are authorized to release information to. You can find this form on our website or you can contact our office. Please be sure to sign the form. Unsigned request cannot be processed.

________________________________ ____________________
Signature of patient or responsible party Date

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INFORMED CONSENT

Thank you for choosing Healing Waters Counseling Center, LLC. We realize that beginning outpatient mental health services is a major decision and that you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Bradley T. Kinder, M.S., LPC, CSAC serves as the founding owner and Clinical Director of Healing Waters Counseling Center. He is a Licensed Professional Counselor and Certified Substance Abuse Counselor through the Virginia Board of Counseling. He has several years of clinical experience in treating children, adolescents, adults and families using individual, group, and family therapy. Other mental health professionals with Healing Waters Counseling Center, LLC are independently licensed (i.e., Licensed Clinical Social Worker, Licensed Professional Counselor, or Licensed Psychiatrist) or are working under the license of a Licensed Clinical Supervisor. If applicable, this will also be discussed with you today, and you will be provided written correspondence of the Supervisor's contact information.
Cognitive Behavioral Therapy is used for most conditions, although other treatment approaches may be used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Virginia State Law, I am obligated to report this to the Virginia Department of Social Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) when required by law, or e) for the purpose of billing and/or collections. I understand that Healing Waters Counseling Center, LLC does not provide emergency services. However, I have been informed of whom to call in an emergency or during weekend and evening hours. I have also been informed of the regular office hours.*

***Signature(s)*____*Date:*________________**

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. If applicable, we ask that at each session you pay your co-pay, co-insurance, or 100% of the allowable charge if your deductible is not met. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover outpatient mental health (behavioral health) services, we request that you pay the balance due at that time. For clients with commercial insurance, or clients with insurances that requires that patient (insured) to pay a copay, co-insurance, and/or unmet deductible, it is the policy of HWCC to store your debit/credit card information on file. The financial information is kept securely on file through a Payment Card Industry Data Security Standard (PCI) compliant company, Complete Merchant Solutions, Inc., whose software is integrated with our electronic health record, Valant Medical Solutions, Inc. Regarding clients with an unpaid balance, after 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Healing Waters Counseling Center, LLC.*

I have received a copy of my fee schedule

Signature(s)____Date___________

Lastly, if you need to cancel or reschedule an appointment, 24 business hours advance notice is required, otherwise you will be billed a no-show fee. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested.***

Signature(s)____Date___________

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COORDINATION OF TREATMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no information will be shared.*

____You may inform my physician(s) **____I decline to inform my physician(s)**

PHYSICIAN NAME:____

CLINIC:____

ADDRESS:____

PHONE:___________________________________

Signature(s)____Date_______

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s)____Date_______________

*May we contact you at home ☐**YES** ☐**NO**? May we contact you at work ☐**YES** ☐**NO?***
*May we contact you by cell phone ☐**YES** ☐**NO?***
Where may we contact you____?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that______________________________________may be treated as a client by Healing Waters Counseling Center, LLC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.*

Signature(s)_______________________________________Date__________

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CLIENT RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

May we contact you at home (circle one) ☐**YES** ☐**NO**? May we contact you at work ☐**YES** ☐**NO?**

May we contact you by cell phone ☐**YES** ☐**NO?** Where may we contact you? ___________________

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy. You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

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Authorization for Disclosure/Exchange of Information

Client Name		DOB		SSN	

I hereby authorize Healing Waters Counseling Services, LLC and ______________________________, at
Person or Agency--one per page

____to exchange information.
Telephone/Address

The type of information to be disclosed:

☐ **Evaluations** [including Diagnostic Interviews and/or Psychological Evaluations]
☐ **Diagnoses**
☐ **Treatment Plan**
☐ **Psychological Test Results**
☐ **Substance Abuse Records/Treatment**
☐ **Course of Treatment** [including progress notes]
☐ **Other** ________________

The purpose of such disclosure:

☐ **Ongoing Treatment**
☐ **Evaluation**
☐ **Transfer**
☐ **Coordination of Care**
☐ **Legal Issues**
☐ **Other**

Exceptions: ____

The designated information about me ☐**may** ☐**may not** be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Healing Waters Counseling Center, LLC and the above designated person ☐**may** ☐**may not** discuss by telephone the content of the information released.

This consent is in effect until ____________________, or for **one year if not specified**. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential, except as provided in § 32.1-127.1:03 of the Virginia State Code and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

________________________ ____
Date Signature of Client (13 or older)

________________________ ____
Date Signature of Parent/Guardian/Authorized Representative

________________________ ____
Date Witness

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PSYCHIATRIC MEDICATION CONSENT AND POLICIES

PATIENT NAME: ____

PATIENT DOB: ______________________

TODAY'S DATE: _______________________

GUARDIAN NAME (IF APPLICABLE): _______________________________________

______________ By **initialing here**, I certify the following:

1. The nature of my condition and the reason for prescribing the specific medication have been explained to me.
2. Alternative treatments and their benefits and disadvantages have been explained to me.
3. The type of medication, dosage, and range of frequency, the route of administration, and the anticipated length of treatment have been explained to me.
4. I understand and accept the possible side effects of the prescribed specific types of psychotropic medication.
5. I understand and accept additional possible side effects that may occur when specific psychotropic medications are taken for extended periods include persistent, involuntary movements of the face, mouth, or extremities (hand/feet). These symptoms are potentially irreversible and may appear after the medications have been discontinued.
6. I understand and accept possible side effects may occur in adolescents and/or children when taking specific psychotropic medications including stunting of growth, sudden cardiac death, and suicidal ideations.
7. I have informed the prescriber of all medications I am currently taking, including prescription, over the counter, herbal, or recreational.
8. I have been advised whether I should avoid drinking alcohol or consuming any or all of said medications while taking the psychotropic medications.

9. I have been advised of the probable consequences of declining recommended or alternative therapies.
10. I have informed the prescriber of all my known allergies.
11. I will not hesitate to ask my provider any questions I may have regarding my treatment.
12. I understand that psychotropic medication therapy may include lab tests, random pill counts, random drug screens (Note: if drug testing is mandated in the office, there will be a $20 fee). Refusal to cooperate may lead to dismissal from the practice.
13. I understand that controlled substances, such as benzodiazepines, stimulants, hypnotics, or gabapentin, are **NOT** prescribed at this facility (Exceptions may be made at provider discretion).
14. I understand therapy services are a **requirement** for medication management. I understand failure to attend scheduled therapy sessions may delay appointment with a prescriber and result in delay of medication refills.
15. When asking the forms be completed by the provider, they will be brought at the time of the next scheduled appointment and will be done so at the provider’s discretion. The provider will be allowed no less than one week to complete if choosing to do so.
16. When calling the office for refills, provider be allowed no less than three business days to fulfill. If refills are needed due to missed appointment, provider may not be allowed to comply until seen again in the office. If the medication needing a refill is a controlled substance, and is due to missed appointment provider will not refill until seen.

I,____, understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments.
- I will participate in all other types of treatment that I am asked to participate in.
- I will keep the medicine safe, secure and out of reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it.

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Tele-Health Policies and Procedures:

PATIENT NAME:____

PATIENT DOB:______________________________

TODAY'S DATE:______________________________

PATIENT GUARDIAN (IF APPLICIABLE):_____________________________________

I,____, understand and voluntarily agree that I:

- Will be in a quiet, private environment at time of appointment.
- Will be signed on to Wi-Fi internet with adequate connection at time of appointment.
- Will not be operating machinery at time of appointment (including driving a car).
- Will alert provider or therapist of all other persons within the room during the appointment.
- Will not record (audio or video) appointment without verbal or written agreement from prescriber or therapist.
- If patient is a minor (under 18 years of age), will have the minor present at time of medication focused appointments.
- If vital signs (blood pressure, heart rate, height, and weight) are requested from provider, this will be collected and presented to provider at time of or before appointment.
- Will assume responsibility to call office accordingly if your Zoom link has not been obtained approximately 5 minutes before appointment or if experiencing technical difficulties.

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Client Screening Form

1. Are you (or the minor child) currently, or are you expecting to be, involved in any legal proceedings?
   a. Yes b. No

2. Are you (or the minor child) currently prescribed any benzodiazepines (Xanax, Klonopin, Ativan), Neurontin/Gabapentin, or other controlled medications?
   a. Yes b. No

3. Are you currently involved in a child custody battle?
   a. Yes b. No

4. Do you anticipate being involved in a child custody battle within the next year?
   a. Yes b. No

5. Have you (or someone on behalf of the minor child) recently applied for Disability?
   a. Yes b. No

6. Have you (or someone on behalf of the minor child) applied for Disability within the past year?
   a. Yes b. No

7. Do you (or someone on behalf of the minor child) expect to apply for Disability within the next year?
   a. Yes b. No

8. Are you (or someone on behalf of the minor child) in the process of applying for Disability?
   a. Yes b. No

9. Do you (or the minor child) have any pending legal charges?
   a. Yes b. No

10. We charge $500 for a half day or $1000 for a full day to come to court. Should your legal, child custody, or disability case require court involvement from HWCC, do you agree to prepay our indicated rates for each provider that is subpoenaed?
    a. Yes   b. No

11. If you are a legal custodial parent of a client being seen at HWCC, do you share custody with anyone else outside of your home?
    a. Yes   b. No

If yes, please provide the following information:

What is the relationship of the client to the outside custodial individual?____

What is the name of the individual that shares custody of the client?____

What is the address of the individual that shares custody of the client?____

What is the phone number of the individual that shares custody of the client?____

12. If you (or your minor child) are involved in legal/court related matters, please indicate the names of all attorneys involved.____
    ____

________________________________   __________________________

Client (18 or over) or Guardian   Date