6832 Convent Boulevard Sylvania, Ohio 43560 419.882.4529
5335 Silica Drive Sylvania, Ohio 43560 419.517.7496

SOPHIA CENTER POLICIES

Fees

Sophia Center, Inc. has developed a fee schedule competitive with other practices in the area. Testing services are also available. Testing charges may be paid through a payment plan.

Financial Arrangements

Please feel free to discuss your financial arrangements with the Office Manager. Payment contracts are available. Payment arrangements must be made prior to your first appointment.

The Office Manager will gladly check with your insurance carrier prior to your first visit to determine your benefits, deductibles and co-pays. Please fax a copy of both sides of your insurance card to: **419.885.7612**. Also, bring your insurance card with you at the time of your visit. If a referral is necessary from your primary care physician, it must be in place prior to your visit. Please call the office to check whether it has been received. Should your insurance carrier change at any time during your course of therapy, it is your responsibility to notify us. You will be responsible for any charges incurred during lapse of coverage.

For those clients without insurance coverage, our Office Manager will be happy to discuss reduced fees for service and a regular payment plan.

Sophia Center, Inc. will make every effort to provide you with accurate information regarding your mental health benefits for counseling and/or testing.

Please be advised however that this is a quote of benefits only and not a guarantee of payment. Your insurance carrier may review your claim(s) and base their decision regarding payment on diagnosis, medical necessity, pre-existing conditions and other contractual restrictions.

Sophia Center, Inc. will assume no liability for denial of claims. All counseling and psychological/neuropsychological testing relationships are made with the client and not the insurance carrier. Not all providers for *Sophia Center, Inc.* participate in all insurance plans.

Insurance Co-Pays

Your co-payment is due at the time of service. Cash, check or credit card will be accepted.

Self Pay

Self pay clients are expected to pay for services at the time they are rendered unless prior arrangements have been made with the Office Manager.

Charity Case Policy

Sophia Center, Inc. offers charitable care for clients providing necessary criteria is met. Please contact the Office Manager to discuss this option.

Sliding Fee Scale

Sophia Center, Inc. offers a sliding fee scale based on Federal guidelines regarding income status. Please contact the Office Manager to discuss this option.

Collection of Account Balances

Medical Billing Associates will send you a statement each month, depicting the client balance owed, and the amount outstanding to your insurance carrier. If there has been no response from your insurance carrier within 90 days, the amount billed to that carrier will become your responsibility. Remember that the agreement for treatment is made between you and *Sophia Center, Inc.*, not your insurance carrier. **You are responsible for all billed charges**.

Client account balances on which payment has not been received within 90 days will be notified by letter from *Medical Billing Associates*, followed by a dismissal letter from the Executive Director of *Sophia Center, Inc.* If this action is necessary, no further appointments will be scheduled at the center and Sophia Center Staff will offer a referral to another agency for continuation of services.

Credit Card Payment

Sophia Center, Inc. accepts *VISA* and *MasterCard*. *Discover* and *American Express* cards are not accepted.

Cancellation Policy

If you find it necessary to cancel an appointment scheduled, **we require 24 hours advance notice**. This courtesy makes it possible to give a cancelled appointment to another client. **There will be a $25 charge for appointments not cancelled within 24 hours**. **Your insurance does not cover charges for cancelled appointments.**

GENERAL CONSENT / CONDITIONS FOR TREATMENT

Consent to Mental Health Treatment: I, the undersigned, consent to and authorize any therapeutic procedures as ordered and deemed necessary by my health care provider. I also indemnify and hold harmless *Sophia Center, inc.* by reason of any claim that might be made as a result of any alleged lack of consent. I acknowledge that no guarantees have been made to me as to the results of treatment.

Medicare Certification and Authorization: I certify that the information given by me applying for payment under *Title VII* of the *Social Security Act* is correct. I authorize any holder of medical or other information about me to release to the *Social Security Administration* or its intermediaries or carries any information needed for this or a related medical claim.

Release of Information: I authorize *Sophia Center, Inc.* and/or their employees or agents to release medical information, which may include my drug/alcohol, psychiatric and/or HIV status or records about me and the treatment for which I am being admitted to any applicable private review organization and/or insurer to return to work. In addition, with a client's signed Release of Information Form, medical/mental health information or records may also be released to any physician, hospital, nursing home, nursing service or any other health care agency as may be so requested in connection with the provision of continuity of medical/mental health care. Re-Disclosure of this information by a third-party is prohibited.

****For Community Medicaid Patients Only: I**nformation necessary to obtain payment for treatment/services rendered will be submitted to the *Lucas County Mental Health Board*, *Ohio Department of Alcohol and Drug Addiction Services* and the *Ohio Department of Mental Health*.

Lost/Stolen Property: I understand that *Sophia Center, Inc.* shall not be held responsible for personal property. Only items necessary for this admission should be contained on the premises.

This consent may be revoked in writing at any time, except to the extent that actions have been taken in reliance thereon, and shall expire when no longer necessary to effectuate its purpose.

Risks and benefits of treatment have been explained to me (us). I understand that I have the right to refuse treatment. If treatment is refused, *Sophia Center, Inc.* staff will, with my approval, offer assistance in developing alternative approaches to ensure that I and/or my minor child(ren) received the needed/recommended services.

NOTICE OF PRIVACY PRACTICES

This notice describes how mental health (psychological) information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit *Sophia Center, Inc.* we make a record of the information gathered during your visit. This information is used for a number of purposes. These uses are set forth below. You have certain rights regarding this information, which are set forth below. Finally, we have certain responsibilities regarding our use of your information, which are also set forth below.

Uses and Disclosures of Mental Health Information

We are permitted by law to use your mental health information to provide treatment to you. For example, we will provide your physician and our other clinicians involved in your care and treatment with the information in our records to assist the physician in providing proper care to you. We will also provide this information to subsequent health care providers. These individuals may create additional information related to the care and treatment they provide you.

We are permitted by law to use your mental health information to obtain payment for our services. For example, we may send your insurance company or other payor a bill that may include your mental health information. In our case, we use a billing service, *Medical Billing Associates*, a collection agency to represent our interests in requesting payment.

We are permitted by law to use your mental health information to perform our regular health care operations. For example, we may use your mental health information to assess the quality of care we provide in order to maintain our standards.

In addition to these uses and disclosures, we may use your information to contact you to provide appointment reminders to you or to advise you of treatment alternatives available to you.

We are permitted, and in **s**ome cases required, by law to make certain other disclosures of mental health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

- To public health agencies to satisfy certain reporting requirements such as births and deaths, certain communicable diseases, child abuse, and other public health issues.

- To health oversight agencies, such as governmental auditors, the Ohio Department of Health, and other agencies when required.

- To any individual when ordered by a court or other legal process to do so.

- To law enforcement officials when necessary for law enforcement purposes and required by law.

- To a coroner or medical examiner when necessary to enable them to perform their duties and to organ procurement organizations, to enable them to make suitability determinations in cases of emergency.

- To researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Other

- If a client states or suggests that he/she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health care professional is required to report this information to the appropriate social service and/or legal authorities.

We will not use your mental health information for any other purpose without your written authorization. You have the right to revoke any authorization you provide us.

YOUR INDIVIDUAL RIGHTS

Your rights include:

- The right to obtain a paper copy of this notice.
- The right to inspect and copy your health information, unless rendered detrimental to your mental health as determined by the providing therapist and subsequent to other limited exceptions (copies are available for a reasonable fee).
- The right to request amendments to your mental health information you believe to be inaccurate.
- The right to obtain an accounting of our uses and disclosures of your mental health information, subject to certain exceptions.
- The right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request).
- The right to request that communications regarding your mental health information be sent by alternative means or at alternative locations.

Our Responsibilities

- We are required by law to maintain the privacy of your mental health information in accordance with this notice.
- We are also required to provide you with this notice explaining our duties and
  practices regarding your mental health information. We are required to abide by the terms of this notice.
- We reserve the right to change the consent of this notice and to make new provisions regarding your protected mental health information. We will provide you a revised notice during your first visit after the revisions are effective.

If you have any questions regarding this notice or wish to exercise any of your rights as described herein, you may contact our Office Manager/Privacy Officer at **419.824.3662** regarding any complaints. Complaints regarding your rights or our practices can also be directed to S. Rachel Nijakowski, Ph.D., Executive Director of *Sophia Center, Inc.* In addition, you can file a complaint with the Office Manager/Privacy Officer for *Sophia Center, Inc.*, by written correspondence. Finally, you can submit a complaint to the Secretary of *Health and Human Services*. We will not retaliate against you for filing a complaint.

Sophia Center

FORM TO RECORD ACKNOWLEDGEMENT

I_____

hereby acknowledge receipt of the **Financial Policies**, I**nsurance Disclaimer**, **Consent for Treatment** and **Notice of Privacy Practices**.

Signature:_____**Date:**_____

Witness:_____**Date:**_____

If signed by a personal representative, relationship to client:

_____

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us, we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

____Home	_____ Phone Number	_____ How should we identify ourselves?	Yes No May we say the clinic name?
____Work	_____ Phone Number	_____ How should we identify ourselves?	Yes No May we say the clinic name?
____Other	_____ Phone Number	_____ How should we identify ourselves?	Yes No May we say the clinic name?