Advance Consent and Assignment for Insurance Benefits

Mahmoud "Mac" Hassan, LMHC
8910 N. Dale Mabry Highway Suite #37
Tampa, FL 33614
Phone: 813-933-2100
Fax: 813-933-2100
Email: tampabaytherapistmac@outlook.com

Please fill out completely, and legibly. Thank you.

I, (patient name) _____ authorize Mahmoud Hassan Counseling/ Tampa Bay Area Therapist and its affiliates (provider) to release the following information and to contact my insurance company, employer, and/or authorized agents with reference to my treatment.

Patient Date of birth: ____ /_____ /_____ Patient Social Security #: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Patient Telephone Numbers: (H)_____ (W) _____ Patient Email: _____

Preferred Method of Communication: Daytime: _____ Evening: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Insurance Information:

With whom is the patient insured? (circle one) SELF PARENT PARTNER OTHER

Insurer's Name: _____ Insurer's Employer: _____

Insurer's Social Security #: _____ Insurer's Date of Birth: ___ /____ /____

Name of Insurance Company: _____

Group #: _____ Policy #: _____.

I understand information to be released will include both written and verbal communications of confidential records regarding psychiatric and/or substance abuse treatment. This will include, but not be limited to, dates of treatment and charges and copies of any and all of my medical records may be provided, if required. I understand this information is to be released for the purpose of receiving insurance benefits and/or payments for utilization review purposes in determining justification for admission, continued stay and changes in levels of care throughout the continuum. Information released is not to be further disclosed for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be signed by me, and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy the information released. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the person(s) and/or agency named herein, which may result in denial of insurance benefits and/or payments. Therefore, I further understand that I am responsible for payment of any and all changes by Mahmoud Hassan Counseling/ Tampa Bay Area Therapist and its affiliates for services.

This authorization is valid until: _____.

*Patient's signature: _____ Date: _____

*Parent/Guardian's signature: _____ Date: _____

I hereby assign payment directly to the above named provider of all or any individual/group health plan benefits and otherwise payable to me but not to exceed the balance due of the provider's regular charges for this period of treatment. I also assign any available major medical benefits. *** I hereby understand that in the event of a denial of an insurance claim that it is my responsibility to pay the above named provider's regular office visit fee

*Insured person's signature: _____ Date: _____

*Witness' signature: _____ Date: _____

* Signatures required: Adult patient (18 or over) and witness; parent (or guardian) and child plus witness if child is age 12–17; parent (or guardian) and witness if child is under age 12 or patient is adjudicated incompetent.

Confidentiality in Therapy

Mahmoud "Mac" Hassan, LMHC
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Before you tell your therapist about yourself, you have the right to know what information can and cannot be kept confidential. Please read this and initial each item only if you understand and agree to the conditions described. If there is anything you don't understand, your therapist will explain it in more detail.

General Extent and Limits of Confidentiality

The laws and ethics governing therapy require that therapists keep all information about clients confidential except for certain types of information and situations. Those exceptions are:

1. *Client's desire:* If you want your therapist or this agency to give information about your case to anyone outside this agency, you must sign a Release of Information giving written permission for this disclosure.

Acknowledgment: **I understand that if I want my therapist or this agency to give information about my case to any outside person or agency, I must sign a Release of Information.**

Initials: _____

2. *Safety:*

a. *Risk of self-harm:* If your words or behavior convince your therapist that you are likely to harm yourself, either deliberately or because you are unable to keep yourself safe, your therapist must do whatever he or she can to prevent you from being harmed. This means the therapist must take action up to and including hospitalizing you with or without your consent. If this situation comes up, your therapist will discuss it with you before taking action unless it appears that this would be unsafe or immediate action is needed to keep you from being harmed.

b. *Risk of harm to others:* If you threaten serious harm to another person, your therapist must try to protect that person. He or she would report your threat to the police, warn the threatened person, and try to prevent you from carrying out your threat. If this situation comes up, your therapist will discuss it with you before taking action unless it appears that this would be unsafe or immediate action is needed to keep you from acting on your threat.

Acknowledgment: **I understand that if my therapist believes there is a serious risk that I will hurt or kill myself or another person, my therapist is legally required to report this, warn the endangered person if someone other than myself, and take whatever action seems needed in his or her professional judgment to prevent harm to myself or others. Initials: _____**

c. *Emergencies:* In an emergency when your health or your life is endangered, your therapist must provide medical personnel or other professionals any information about you that is needed to protect your life, but only information that is needed for that purpose. If possible, your therapist would discuss it with you and get your permission first. If not, he or she would talk with you about it afterward.

Acknowledgment: **I understand that in an emergency when my health or life is in danger, my therapist must give other professionals any information about me that is needed to protect my life. Initials: __**

3. *Abuse:* If your therapist obtains information leading him or her to believe or suspect that someone is abusing a child, a senior citizen, or a disabled person, the therapist must report this to a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. The therapist cannot investigate and decide whether abuse is taking place: if the suspicion is there, the therapist must report it. The state agency will investigate. If you are involved in a situation of this kind, you should discuss it with a lawyer before telling your therapist anything about it unless you are willing to have the therapist make such a report. If this situation comes up, your therapist will discuss it with you if possible before making a report.

Acknowledgment: **I understand that if my therapist believes or suspects that a child, a senior citizen, or a disabled person is being abused or neglected, my therapist must report this to a state agency who will then investigate the situation. Initials: _____**

4. *Therapy of children, families, and couples:*

a. *Children and adolescents:* It is the policy of this agency, when a therapist treats children and adolescents, to ask their parents or guardians to agree that most details of what their children or adolescents tell the therapist will be treated as confidential. However, parents or guardians do have the right to *general* information about how therapy is going. The therapist may also have to tell parents or guardians about information if their children or others are in any danger. If this situation comes up, the therapist will discuss it with the child or adolescent first before talking to the parents or guardians.

Acknowledgment: **I understand that if my child or adolescent is in therapy, the therapist will give me as the parent or guardian only general information about therapy, except that the therapist will tell me if he or she finds out from my child or adolescent that they or others are in danger. Initials: _____**

b. *Families:* At the start of family therapy all participants must have a clear understanding of any limits on confidentiality that may exist. The family must also specify which members of the family must sign Release of Information forms if necessary for the records of family therapy.

Acknowledgment: **I understand that in family therapy, all members of the family must understand the limits of confidentiality and must agree on which family members will have the power to sign Release of Information forms authorizing disclosure of information about the family's history or treatment. Initials: _____**

c. *Couples:* If one member of a couple tells a therapist something the other member does not know, and not knowing this could harm him or her, the therapist cannot promise to keep it confidential from the other person. If this occurs the therapist will discuss it with you before doing anything else.

Acknowledgment: **I understand that if I am in couple's therapy and tell the therapist something my partner does not know, and not knowing this could harm my partner, the therapist and this agency cannot promise to keep that information confidential from my partner. Initials: ____**

5. *Group therapy:* In group therapy, the other members of the group are not therapists. They are not bound by the ethical rules and laws governing therapists. To avoid problems in this area, it is this agency's policy to ask all members of therapy groups to agree to protect one another's confidentiality, and to remove from the group any member who does violate another member's confidentiality. Still, this agency cannot be responsible for such disclosures by other clients, and it may be better for you to discuss information you feel must be legally protected in an individual session with your therapist than in a therapy group session.

Acknowledgment: **I understand that in group therapy, I do not have the same degree of confidentiality in group sessions that I have in individual sessions with my therapist, and that other group members are not therapists and are not bound by the ethical rules and laws governing therapists. Initials: _**

6. *Professional consultation:* Your therapist may consult with a clinical supervisor or another colleague about your treatment. The other therapist must give you the same confidentiality as your therapist.

If this fellow therapist is employed at this agency, no written authorization from you is required. If your therapist discusses your case with a professional outside this agency, such as a therapist who treated you in the past, he or she must get your written permission (a Release of Information form) first. If another professional asks your therapist for information about you during or after your treatment, your therapist cannot provide any information unless that other professional provides a Release of Information which you have signed authorizing your therapist to provide that information.

Acknowledgment: **I understand that my therapist may discuss my history and treatment with other therapists for professional purposes, and that if these other therapists are not employed at this same agency my therapist must get my specific written permission in advance. Initials:**

7. *Legal proceedings:* If a judge orders your therapist to provide information about your history or your treatment, the therapist must do so.

Acknowledgment: **I understand that if ordered by a judge, my therapist must give the court whatever information about my case the judge rules to be necessary. Initials: _____**

8. *Debt collections:* If you fail to pay for services as agreed, and other methods of resolving the problem fail, Mahmoud Hassan, MS may have to use a collection agency or other legal means to collect the fees you owe. The only information the agency would disclose for this purpose would be your name and address, the dates you received services, and the amount of your unpaid balance.

Acknowledgment: **I understand that if I fail to meet my financial obligation to this agency and it becomes necessary to use legal means to collect my fees, the agency may disclose my name, address, dates of services, and balance due for this purpose. Initials: _____**

9. *Recording therapy:* This agency will not record therapy sessions on audiotape or videotape without your written permission. If you give permission for such recording, you have the right to know who will see or hear the recording, for what purpose(s) it will be used, and when it will be erased or destroyed.

Acknowledgment: **I understand that my therapy will not be recorded on audiotape or videotape without my written permission. Initials: _____**

10. *Referring agencies and conditions of treatment:* If you have been involuntarily referred for treatment by a court or a government agency such as a probation department or Child Protective Services, your treatment may include requirements that you comply with conditions including reporting of information about your therapy to the agency that referred you for treatment, or reporting to that agency if you appear to have violated laws regarding substance abuse or agency rules regarding satisfactory participation in this program. If such reporting requirements exist, your therapist will tell you about them before you start therapy, and will notify you when making any such required reports.

Acknowledgment: **I understand that if I have been involuntarily referred for treatment by a court or government agency, the conditions of my therapy may include mandatory reporting to the referring authority about my therapy and/or any violations I commit of laws regarding substance abuse or of agency rules regarding my conduct while in this program. Initials: _____**

11. *Independent disclosure by client:* Any information that you yourself share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

Acknowledgment: **I understand that if I myself willingly and publicly disclose information about my therapy, that information is no longer confidential or legally protected. Initials: __**

Our signatures here show that we have read, understand, and agree to the conditions presented above.

Client Name(s): _____ Date: _____/_____/_____

Signature: _____

Parent/Guardian Name: _____ Date: _____/_____/_____

Signature: _____

Therapist Name: _____ Date: _____/_____/_____

Signature: _____

-Authorization to Release Mental Health Care Information

Mahmoud "Mac" Hassan, LMHC
8910 N. Dale Mabry Highway Suite #37
Tampa, FL 33614
Phone: 813-933-2100
Fax: 813-933-2100

Patient's Name:_____

Date of Birth:_____

Social Security Number:_____

I request and authorize the mutual release of health care information of the patient named above between Mahmoud Hassan Counseling/ Tampa Bay Area Therapist/its affiliates and:

Name:_____

Address:_____

This request and authorization applies to:

Health care information relating to the following treatment, condition or dates of treatment:

All health care information
Other:

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE DATE IT IS SIGNED AND MAY BE REVOKED AT ANY TIME UPON WRITTEN REQUEST OF THE CLIENT EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN.

Signature of patient or patient's authorized representative_____ **Date signed**_____

Relationship or status if signed by anyone other than patient (parents, etc.) _____.

Fee Agreement

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* * PLEASE READ THIS DOCUMENT THOROUGHLY * * * * BEFORE SIGNING * *

I, _____, agree to pay a fee of $_____ to (Tampa Bay Area Therapist/Mahmoud "Mac" Hassan, LMHC) for each 45-50 minute counseling/therapy session held or not canceled with notice as stated on this agreement form. I also agree to the fee schedule for additional services as stated below.

I HAVE READ AND UNDERSTAND THESE OFFICE AND FINANCIAL POLICIES, AND AGREE TO THOSE TERMS. **Payment is due at time of service.**

Fee Schedule

Individual/Family Therapy Session	**$____/hr.**
Sliding Scale Fee Agreement :_____	**Initials_____**
Report/Letter Preparation	**$_____/hr.**
Telephone Calls/Emails/Consults with Client/ Parent(s) Exceeding 15 Minutes in Length	**$_____/hr.**
Consultation with Other Professionals (lawyers, doctors, therapists, etc.) as Requested and/or approved by Client/Parent(s)	**$_____/hr. (including travel time if not by if not by telephone)**
Home Visits	**$_____/hr. (including travel time)**
Court Testimony	**$____/hr. (including preparation time, travel, reports, waiting, and testimony)**

Client's Signature_____
(responsible party's signature if client is a minor):_____

Effective date:_____ If Payment is due after insurance has paid and payment is your responsible and is not paid Tampa Bay Therapist & Associates decide to write off this debt, we will use IRS form 1099-A, which will show the IRS that the Amount owed became income for you and bad debt for Tampa Bay Therapist & Associates.

Policy Regarding Missed Sessions

Mahmoud "Mac" Hassan, LMHC
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I believe that it is important for clients to attend all sessions scheduled for them, except, of course, in an emergency. Missed or canceled sessions are counterproductive and increase the time it takes to bring about the changes which you entered counseling to make. The policy of this office, therefore, is to bill you for all missed sessions not canceled 24 hours in advance of your appointment. I will try to reschedule these sessions for you during the same week. If you miss a session without notice or within 24 hour, I will bill $_____ you directly. Insurance and managed care companies rarely, if ever, pay for sessions that you miss and it would be fraudulent for me to submit a claim for these.

Please sign the following statement to indicate that you have read and understood this policy:

> *I have read and understood your policy concerning missed sessions. I understand that I will be billed for all avoidable missed sessions and late cancellations for which I have not given 24 hours' notice. I agree to pay for these sessions.*

Client's Signature_____ Date_____
(parent if client is a minor)

Disclosure Statement

Mahmoud "Mac" Hassan, LMHC
8910 N. Dale Mabry Highway Suite #37
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Thank you for considering my counseling services. In order to help you make an informed decision, I have prepared this statement for you to read. Please review this statement in its entirety and sign it in the space provided. If you have any questions or concerns, I would be pleased to discuss them with you.

Types of Counseling Provided

The types of counseling services I provide are generally directed toward children, adults, adolescents, and families. Issues such as self-esteem, substance/alcohol dependence, behavioral difficulties in school and/or home, divorce or separation, bereavement, and difficulties in family communication are among the range of situations with which I typically work. I also provide counseling services to children ages 5-16. I have a vast amount of experience with child welfare and I am an adoption competent therapist.

For Adults, I provide therapy in individual or couples format. Individual counseling is my most frequently used modality, with group counseling being provided or offered as warranted.

Education, Training, and Experience

I have been in private practice since 2005. My highest degree is an M.S. in Psychology from Nova Southeastern University in Fort Lauderdale, Florida. The bulk of my education prior to that was taken in New York City, where I am from originally. I have also had additional graduate-level training in Counseling and Human Development from the University of South Florida, where I have earned a baccalaureate degree in Psychology. I am also a certified Eye Movement Desensitization and Reprocessing (EMDR) therapist.

I have been working with children and families in various capacities since 1999. I have served as a counselor/therapist for public and private sector organizations, and have worked for schools, and non-profit agencies. My work has also included working in a 28- day residential program as a primary therapist for individuals with a wide range of mental health and substance abuse disorders. I have experience in therapy with people of all ages, alternate lifestyles, many faiths and individuals from varying ethnic and cultural backgrounds- regardless of their socioeconomic status. I have worked with females and I am sensitive to feminine issues in counseling. I believe that my diversity of experiences has provided me with a range of skills and an ability to flexibly approach each client's unique circumstances.

Methods of Counseling

My approach to counseling is interactive in style and based on the empathic response model, which emphasizes the importance of understanding and coming to terms with feelings. My philosophy of counseling is based on the belief that the client possesses the power to change, and that it is my role to help the client become aware of how to understand and utilize that power. I also employ techniques of EMDR and cognitive-behavioral therapy (CBT), which empowers the client to challenge your internal

thinking process to motivate positive change in your life. This is a philosophy of empowerment---it accepts the client as the driving force in change. I believe this approach brings about effective long-term results, for the reason that the client discovers how to utilize his/her own inner strengths and gifts rather than having to rely on someone else for solutions to life's difficult issues.

If you should have questions or concerns, please do not hesitate to bring them up. My goal is to have counseling be a positive, productive part of my clients' lives. I will give my utmost effort to help accomplish this goal.

I have read this disclosure statement and understand its content. I also acknowledge receiving a copy of this statement. I have been provided with a fee agreement stating the agreed cost of counseling sessions and policies regarding payments.

Signature:_____
(responsible party if client is a minor)

Date:_____

Counselor's Signature:_____

Date:_____

Part E. Payment Information

Person responsible for session payments; _____

Phone Contact: _____

I authorize that my credit card may be kept on file: _____Yes _____ No (Initials) _____

There is a $_____ fee to process credit/Debit card

Card Type:_____

Card Number:_____

CVV ___

Expiration Date:_____

Billing Zip:_____

Signature: _____ **DATE:**_____

STOP HERE.

THANK **YOU**

for being amazing and
working SO hard to accurately
fill out this information!