

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
Standard Payment for Private Insurance and Self Pay for Mental Health Evaluation and Treatment Section ___/# _____	Ana Dutcher Quality Assurance Manager	4/1/19	4/1/19	Page 1 of 15

Approved By: Mohamad Khraizat	Title: Manager of Health Operations
Signature: 	Date: 4-8-19

I. POLICY:

ACCESS CHRC will provide services for private insurance and self-pay/out of pocket clients with the financial responsibility left to the client. Although we accept insurance, the client is still responsible for the payment of the services if insurance denies the claim. Client will be responsible to co-pays and deductibles which are due upfront before the service is provided.

II. PURPOSE:

The purpose of this policy is to delineate, describe, and prescribe the procedures for the private insurance and self-pay/out of pocket clients.

III. APPLICATION:

This policy applies to ACCESS staff, its affiliates, and contractors, who provide mental health or substance abuse services, supports and treatment on behalf of ACCESS.

IV. DEFINITIONS:

Private Insurance: Clients who use an insurance plan are responsible for any amount not paid by their insurance provider.

Payments: Cash and credit cards only

Self-Pay/Out of Pocket: 100% responsible for payment. Client will be paying for services before service is rendered.

V. PROCEDURES:

- A. The Intake and Health Benefit Specialist
1. Will create the file in the EMR
 2. Will document the client's benefits (Private Insurance or Self-Pay)
 3. Assign the case to the physician, physician assistant or therapist

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4. Consents are signed
 - a. Financial Responsibility Agreement
 - b. HIPAA Notice
 - c. Consent for Treatment
 5. An appointment is provided
- B. The physician, physician assistant or therapist must perform the assessment, diagnose and recommend treatment
- C. The following services are available for Private Insurance and Self-Pay Clients
1. Psychiatric diagnostic evaluation (no medical services) 90791, 90792
 2. Medication Review 10 min. E/M visit
 3. Mental Health Assessment – Biopsychosocial 90791
 4. Psychotherapy, 30 (16-37 mins)
 5. Psychotherapy, 45 (38-52 mins)
 6. Psychotherapy, 60 (53+)
- D. Fee schedule for services available for Private Insurance and Self-Pay Clients

CPT Code	Description	Out of Pocket
90791	Psychiatric diagnostic evaluation (no medical services)	\$ 150.00
90832	Psychotherapy, 30 (16-37 mins)	\$ 50.00
90837	Psychotherapy, 60 (53+)	\$ 100.00
99212	Medication Review 10 min. E/M visit	\$ 50.00
H0031 BI /H0001 ZA	Mental Health Assessment, Biopsychosocial	\$ 130.00
H2030	Clubhouse (15-minute units)	\$ 4.25
96101	Psychological Testing (per hour up to 6 hours)	\$ 125.00

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E. Mental Health Evaluation components

1. The assessment or mental status exam is to identify appropriate subjective and objective information pertinent to the patient's presenting complaint. The presenting symptoms are to be clearly identified with the onset, duration and intensity documented.
2. The assessment contains the patient's presenting problem(s) as well as relevant psychological or social conditions affecting the patient's medical or psychiatric status. For children and adolescents (18 and under), past medical history and psychiatric history includes prenatal and perinatal events and a complete developmental history (physical, psychological, social, intellectual, and academic).
3. The mental status exam is to document the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, impulse control, suicidal ideation and homicidal ideation.
4. For patients 10 years and older, there is to be an appropriate notation in the assessment concerning past and present use of tobacco, alcohol, as well as illicit, prescribed and over- the-counter substances.
5. Past medical/behavioral history is easily identifiable in the record and includes, if applicable; previous treatment dates, former provider information, therapeutic interventions and responses, source of clinical data, relevant family information, results of lab test and consultation reports
6. To determine if a comprehensive substance use disorder (SUD) evaluation is needed, a SUD screening is to be incorporated into the assessment of all new patients

- F. Payments for Self-Pay clients, co-pays and deductibles will be received at the front desk at the time of check-in.

V. QUALITY ASSURANCE/ IMPROVEMENT:

ACCESS Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

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VI. COMPLIANCE WITH ALL APPLICABLE LAWS:

ACCESS, its affiliates, service providers, and other contracted and subcontracted employees are bound by all applicable local, state and federal laws, rules, regulations, all Federal waiver requirements, and state and county contractual requirements, policies and administrative directives in effect, or as amended.

VII. LEGAL AUTHORITY AND REFERENCES:

Agency Policies (All Agency Policies refer to the most recent at the time of writing)

VIII. ATTACHMENTS:

Financial Responsibility Agreement
HIPAA Notice
Consent for Treatment

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Financial Responsibility Agreement

YOU ARE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE, AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICES.

THANK YOU.

We will make your payment as easy and convenient as possible. You may pay by cash, credit card, or debit card. Please read the following and sign at the bottom to accept these terms.

I, _____, agree to pay my co-pay, deductible, co-insurance,

(Client Name Printed)

and any past-due balance on my account at the time of service. I recognize that non-payment of fees will result in ACCESS CHRC rescheduling my appointment.

Assignment of Insurance Benefits: I hereby authorize payment directly to ACCESS CHRC and all providers involved in my treatment or diagnosis at ACCESS CHRC by the group insurance, major medical insurance, and any other insurance payable to or on behalf of the undersigned, by virtue of outpatient services of the below named patient. I unconditionally assign any insurance benefits to ACCESS CHRC and all providers involved in my treatment. **I understand that I am financially responsible to ACCESS CHRC for all charges not paid by insurance.** If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt.

Client or Responsible Party Signature

Date Signed

Staff Providing Notice

Date signed

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HIPAA**Notice of Privacy Practices***Effective Date: September 23, 2013*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact ACCESS at 313-945-8124.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

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For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our consumers receive quality care and to operate and manage our organization. For example, we may use and disclose information to make sure the counseling you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with your provider. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

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To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform registration or billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

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Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify



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family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to ACCESS. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your

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record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to ACCESS.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to ACCESS.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to ACCESS. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to ACCESS. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Rawha Abouarabi at (313) 945-8138. All complaints must be made in writing.

You will not be penalized for filing a complaint.

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HIPAA

Notice of Privacy Practices

Effective Date: September 23, 2013

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

I, _____, hereby acknowledge that I have received a copy of the HIPAA notice of Privacy Practice with an effective date of September 23, 2013.

 Client Signature

 Date

 Parent/Guardian Signature

 Date

 Witness Signature

 Date

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Consent for Treatment

I have chosen to receive mental health services for myself and/or my child from ACCESS CHRC. My decision is voluntary, and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services: I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan: I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision: I understand there are certain circumstances which may require ACCESS CHRC provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
4. Other special circumstances, such as preparation to testify in court

Client Rights: The right to be treated with dignity and respect by all staff

- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff

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- The right to confidentiality of clinical records and personal information according to federal and state laws

Emergencies: I understand I may reach my ACCESS CHRC provider at 313-945-8138. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency situation, I may call 911.

I have read, discussed and understood all of the above.

Client or Responsible Party Signature

Date Signed

Staff Providing Notice

Date signed