

Jennifer Bois, PLLC ~ dba A Peaceful Balance Counseling
 154 Broad Street, Suite 1511
 Nashua, NH 03063

Client Billing Release & Information -Adult

Client Information

Today's Date:	Cell Phone:
Legal Name of Client:	Other Phone:
Preferred Name:	DOB:
Pronouns:	Gender Identity:
Address:	Profession:
City/State/Zip:	Email Address:

Please list at least one adult emergency contact:

Legal Name:	Legal Name:
Relation to client:	Relation to client:
Cell Phone:	Cell Phone:
DOB:	DOB:

Insurance Information

PRIMARY

SECONDARY

Name of Insured:		
Insurance Company:		
ID #		
Group #:		
Subscriber Name:		
DOB:		
Subscriber Social Sec. #		
Name of Employer:		
Client Relationship to Subscriber:		
CO-PAY \$	Annual Deductible \$	CO-PAY \$ Annual Deductible \$
Mental Health Phone #:		
Diagnosis Code(s):		

I authorize the release of any medical or other information necessary to process claims associated with the above patient. I authorize payment of medical benefits to Jennifer Bois, PLLC, LCMHC, Gender Specialist. I understand and agree that if the insurance/billing agency named above denies payment for any reason, I then become responsible for payment of all past and future sessions. I will be responsible for all deductible payments. I understand I will be charged **\$100.00** for any missed sessions or late cancellations that are not reported within 24 hours prior to scheduled appointment.

Legal Name must be used to sign all documents.

 Client or Guardian Signature

 Date



Jennifer Bois, PLLC, LCMHC
Clinical Consultation & Counseling Services
154 Broad Street, Suite 1511
Nashua, NH 03063

Billing Agreement

I understand it is my responsibility to pay for sessions not covered by insurance. This can happen for a variety of reasons, including lapse in your insurance coverage, copayments, deductibles, and missed, rescheduled, or cancelled sessions without 24-hour notification.

Client Name (Printed): _____

Guarantor Name (Person responsible for payment): _____

Guarantor is: Self Parent/Legal Guardian Significant Other

Other Relationship (Please indicate relationship: _____)

By signing this document, I am indicating that I understand that I am legally responsible for payment of fees, and I agree to this policy as indicated above.

Guarantor Signature: _____

Date: _____

Jennifer Bois, PLLC, LCMHC, Gender Specialist
154 Broad Street, Suite 1511
Nashua, NH 03063
Phone: 603-577-5551 ~ Fax: 603-577-5576
www.apeacefulbalance.com

ACKNOWLEDGEMENT AND ACCEPTANCE

I have received, read, and understood the office policies & information/ informed consent for Jennifer Bois PLLC, LCMHC, including information regarding;

1. Code of Ethics
2. Confidentiality
3. Reporting Requirements
4. Maintaining Professional Boundaries
5. Limits of Availability
6. Recommended Treatment
7. Office Policies and Cost of Services
8. Patient Bill of Rights
9. NH Mental Health Bill of Rights

I understand that I am required to pay at time of service and that I will be responsible for any missed sessions or sessions not cancelled within 24 hours, as the time has been reserved for you. I will be charged the rate of \$100.00 per missed session, even if my sessions are usually paid for by another source. I also understand that I am financially responsible for any claims that are denied by my insurance company and for annual deductibles. Insurance companies will not pay for sessions until you meet your deductible amount, so you will be required to pay for the full session as allowed by insurance company.

My signature below indicates that I have read and understand this document and agree to abide by its terms.

Client Signature

Printed Name

Date: _____

If Applicable:

Parent/Guardian Signature

Printed Name

Date: _____



Jennifer Bois PLLC, LCMHC
154 Broad St, STE 1511
Nashua, NH 03063
(603) 577-5551 x2
www.apeacefulbalance.com

AUTOMATIC CREDIT/DEBIT CARD AUTHORIZATION FORM

For your convenience, I am able to keep credit card information securely on file for the purpose of session payment, copays for insurance, payments toward deductible (if applicable), overdue balances, and missed appointment fees. Electronic credit card records will be stored in an encrypted program. A **\$4.00 fee** will be charged for use of credit card each session to help cover processing costs.

Please keep your credit card information current, and notify your provider of any changes in card or expiration date. Please remember the missed session ("no show") fee or sessions cancelled without 24-hour notice, is **\$100.00 per session**, unless another arrangement has been made with the provider in advance. You may opt out of this agreement at any time by notifying provider. An electronic receipt will be emailed to you following a payment. By signing this, you agree to have your credit card charged for services rendered and understand the terms of this agreement.

Effective Date: _____

Name of Patient: _____

I, _____, agree to provide the following credit card information and allow the credit card listed below to be automatically charged as follows;

Credit Card Type: ___ MasterCard ___ Visa ___ Amex ___ Discover ___ Venmo

Name as listed on Credit Card: _____

Zip Code: _____

Credit Card Number: _____

Expiration Date: _____ Security Code (3-digit code on back of card): _____

Email Address: _____

This card may be charged for the following transactions: DEDUCTIBLE: _____

- Co-Pays, Session Payments, and Missed Session Charges.

- **\$4.00 for credit card fees**

PRIVATE PAY/COPAY AMT: _____

Venmo payment to : @JenniferBois71 (no additional fees)

Your Venmo: _____

Signature: _____ Date: _____

Jennifer Bois, LCMHC, WPATH Gender Specialist
 154 Broad Street # 1511 | Nashua, NH 03063

Good Faith Estimate for Health Care Services

Patient Full Legal Name:			
Preferred Name:		Date of Birth: ___/___/___	
Street or PO Box			
City State Zip Code:			
Patient Primary Phone:			
Parent/Guardian(s):			
Insurance: This good faith estimate is if you were paying out of pocket for services. This does not include insurance deductibles. Insurance companies typically set their own rates and have deductibles, so the amount could vary.			
Date(s) of Service	Description	Service Code	Estimated amount to be billed
First session:	Psychiatric Diagnostic Evaluation	90791	\$175
Per Session:	45-60 min individual psychotherapy	90837	\$165
Missed Session	Missed Session Fee: \$100.00		
	Evaluations: Cost Varies		
Total estimate of what you may owe based on 1x weekly sessions. Costs will differ based on frequency of sessions or missed session fees.			Multiplied by 46 weeks: \$7765.00
Provider signature: <i>Jennifer Bois, LCMHC</i>		Date:	
NPI: 1821163247	TIN: 205788553	NPI-2: 1578262572	

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan. **Disclaimer** This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment such as deductibles, or you could be charged more if special circumstances occur, including report writing or other services provided.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you

must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059. Keep a copy of this Good Faith Estimate in a safe place.

Good Faith Estimate:

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above:

Patient/Parent Signature

Date

Jennifer Bois, PLLC, LCMHC
Informed Consent for Teletherapy
Licensed in NH, VT, MA

Telehealth, or Teletherapy is the delivery of behavioral health services using interactive technologies (video) between a therapist and a client who is not in the same physical location. Teletherapy services will be provided through the HIPAA compliant, encrypted secure software service, Zoom Health Professional.

Both the therapist and the client agree;

- Not to record or store these sessions.
- Sessions are connected through an email link from provider.
- Video camera must be ON throughout the session
- Client must be in a place where session can be private/uninterrupted.
- Client must be in their home state during online session, where provider is licensed to practice, unless otherwise allowed by provider licensure board or your insurance company.
- Clients have up to 10 minutes to connect with provider at appt time and if connection is not made within this time period, client will be charged a missed session fee (100.00) as the time was reserved for you. (unless notified otherwise)

There are some potential risks and benefits of teletherapy including, but not limited to:

Risks

- Interruptions, technological failures such as unclear video, loss of sound, poor internet connection or loss of internet connection. Delays in treatment due to equipment failure could occur.
- Additional burden on the client to ensure that sessions are private and uninterrupted
- Limits to nonverbal communication that is present during face-to-face sessions
- The need to electronically share and sign practice forms and information which requires an acceptance of the risks that come with transmitting information and documents over the internet, fax, or via cell phone.

Benefits

- Ability to participate in treatment from your home and maintain continuity of therapy during times of quarantine and/or national or local emergencies; transportation problems, inclement weather, health and disability issues, and rural locations.
- Access to care by enabling individuals to stay in their community while having access to expertise by a counselor/specialist.

Telehealth is not designed for emergency services. By signing this consent, you agree to seek emergency services through your local emergency room or call 911 if you feel that you or your child has a life-threatening emergency. By signing this document, client agrees, that in the event of an emergent or life-threatening emergency situation during a Telehealth session, they will proceed to the closest emergency room and/or call 911. 988 is the suicide prevention and crisis line.

Jennifer holds no legal responsibility for clients (or client caretakers) who do not seek emergency medical services when recommended for emergency care and/or do not follow through with medical advice provided by Jennifer Bois, PLLC, LCMHC.

The same confidentiality protections, limits to confidentiality, and my policies and procedures for practice and payment/billing apply to teletherapy as they would to an in-person session. If a medical emergency situation occurs during a telehealth session, identifying information may be provided to emergency personnel for safety. This is an exception to confidentiality.

Mandated Reporting

Mandated reporting laws in New Hampshire, Vermont, and Massachusetts, require the counselor to report suspected or reported child abuse or neglect, as well as the abuse or neglect of elderly or disabled adults. This is an exception to confidentiality.

Best Practices

- Ensure that your location is private and secure. Try to conduct your session in a room that allows you to separate yourself from others in the home/location to avoid distractions.
- Proper lighting is necessary to ensure a clear image of each party's face.
- Only agreed upon participants will be present; the presence of individuals unapproved by both parties will be cause for termination of the session.
- Client must disclose the current physical location at the start of sessions
- Client shall provide a phone number in the event of service disruption.

Payment Procedures

At the present time, most insurance companies will reimburse for telehealth services. You are still responsible for the payment of copays, co-insurance, and deductible balances. Missed sessions not cancelled within 24 hours will still be subject to missed session fee of \$100.00.

Payment due at time of service. PAYMENT OPTIONS FOR COPAYS OR BALANCES DUE:

- For online sessions: Check (Made out to Jennifer Bois), Credit Card which will be securely stored securely.

Mail Checks to: Jennifer Bois, 154 Broad St, Ste 1511, Nashua, NH 03063

- **Venmo: @JenniferBois71**
(Please use initials of adult client or minor in description area)

Thank you!
Please return following page only, with signature.

Jennifer Bois PLLC, LCMHC – Telehealth Informed Consent Acknowledgement

Consent for Telehealth:

I consent to engage in teletherapy with Jennifer Bois, PLLC, LCMHC. I understand that telehealth includes mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive video, and/or data communications. I understand that Jennifer Bois utilizes the HIPPA compliant Zoom Health Professional platform to protect my health information while engaging in telehealth services. I certify that I have read this form and fully understand its contents including the risks and benefits of telehealth. **I understand that I have been advised to call 911 or proceed to my local emergency room for life-threatening emergencies.** I understand the limits to confidentiality. By signing this document, I certify that I agree with and understand its terms, and have been given the opportunity to ask questions and that questions have been answered to my satisfaction. I will be on time for my appointments. After 10 minutes, I understand my appt will be considered a “no show,” and you will be responsible for a missed session fee of \$100.00.

Client Name (Printed): _____

Client Signature: _____

Parent/Legal Guardian Signature (if applicable): _____

Date : _____ Client Phone: _____

Email to be used for telehealth sessions: _____

If Applicable (minors):

Parent Name/Phone: _____

Parent Name/Phone: _____

Jennifer Bois, PLLC, LCMHC, Gender Specialist
 154 Broad Street, Suite 1511
 Nashua, NH 03063

CLIENT INFORMATION - ADULT

Legal Name _____ DOB: _____ Age: _____

Preferred Name: _____ Assigned Gender: _____ Gender Expression: _____

Pronouns: _____

Please List Those Living In The Home With You:

Name	Age	Relationship	Name	Age	Relationship

Were you adopted? _____ If yes, at what age? _____ Current level of education/years completed? _____

Occupation: _____ Current School/Employer: _____

MEDICAL HISTORY

Are you legally disabled? No Yes

Please check and explain those that may have occurred at any time. CONFIDENTIAL

RESPIRATORY PROBLEMS Asthma _____ Emphysema _____ Bronchitis _____ Other _____	INFECTIOUS DISEASES STD/STI _____ Tuberculosis (TB) _____ HPV _____ Hepatitis _____ Type: _____ Other _____
URINARY/REPRODUCTIVE PROBLEMS Kidney _____ PMS _____ Frequent UTI's _____ Menopause _____ PCOS _____ Other _____	NEUROLOGICAL PROBLEMS Seizure Disorder _____ Head Trauma _____ Brain Injury _____ Concussion _____ Other _____
HEART/BLOOD PROBLEMS Stroke _____ Anemia _____ Hypoglycemia _____ High Blood Pressure _____ Low Blood Pressure _____ Other _____	OTHER SIGNIFICANT ILLNESSES/CONDITIONS Cancer _____ Type of Cancer: _____ Thyroid _____ Diabetes _____ Cirrhosis _____ Lyme Disease _____ Other _____

ALLERGIES Medications:	ALLERGIES Food/Other:
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Do the following occur frequently? (Check and explain all those that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Eye/Vision problems
<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Skin Rashes
<input type="checkbox"/> Nausea
<input type="checkbox"/> Coughs
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Labored Breathing
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Headaches/Migraine
<input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Chest Pains
<input type="checkbox"/> Sleep Disturbances
<input type="checkbox"/> Changes in appetite/weight
<input type="checkbox"/> Falls/injuries
<input type="checkbox"/> Numbness in limbs
<input type="checkbox"/> Fainting Spells
<input type="checkbox"/> Vomiting/Induced
<input type="checkbox"/> Bingeing
<input type="checkbox"/> Vomiting/non-induced | <input type="checkbox"/> Blood Pressure Problems
<input type="checkbox"/> Constipation
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Falls/Injuries
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Balance problems
<input type="checkbox"/> Chronic Pain |
|---|--|--|

Additional Physical/Medical Information or Symptoms:

Have you ever been to a hospital emergency room for mental health reasons? No Yes

HOSPITALIZATIONS/MEDICAL TREATMENTS/MAJOR OPERATIONS/RESIDENTIAL TREATMENTS

(Name of facility/physician – reason for admission/procedure – outcome)

<u>DATES</u>	<u>DESCRIPTIONS</u>

MEDICATIONS CURRENTLY TAKEN (over the counter, prescription, herbal supplements) List separately

<u>NAME</u>	<u>DOSE</u>	<u>REASON FOR TAKING</u>	<u>Prescribing Physician</u>
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MEDICAL CARE

Primary Care Physician: _____ Phone: _____

Date of last physical: _____

Have you ever been evaluated at a hospital emergency room for mental health reasons? _____

Do you have any learning, reading, or developmental disabilities that could impact treatment?

Do you have difficulty concentrating on a regular basis? _____ How long has this happened? _____

Have you ever engaged in atypical eating patterns for weight management? (Not eating, restricted eating, hoarding food, binge eating, purging, laxatives, preoccupation with food, dieting, calories, fat content, or weight)

Have you ever compulsively picked your skin, face, nails/cuticles, scabs, head, or pulled your hair out (including eyelashes/brows), to the degree that resulted in hair loss, scarring, or other skin damage? _____

Have you ever questioned your gender identity or experienced the desire to be a different gender to the point that it caused you great distress? _____ No _____ Yes At what age did this begin? _____

Do you have any problems sleeping? If yes, please describe; also include if you experience sleepwalking, night terrors/nightmares/sleep paralysis/chronic insomnia

Have you ever experienced a concussion, stitches, or any other head injury? _____ No _____ Yes, age: _____
If yes, please describe circumstances:

Have you ever lost consciousness? _____ If yes, How long were you unconscious? _____

Have you ever cut or burned yourself, or engaged in another form of intentional self-injury? _____

SUBSTANCE USE

CONFIDENTIAL

Substance used	No	Past use	Yes/Current: Please Specify substances used/type:	Current Frequency of use (how often)	How much do You use? (avg.)
Caffeine					
Tobacco					
Alcohol					
Marijuana (recreational)					
Marijuana (medical)					
Over the Counter Meds. (For recreational use)					
Prescription Medications (For recreational use)					
Illegal drugs – psychodelic, Opiates, "uppers" ETC					
"Alternative" & Herbal Substances					
Inhalants					
Fentanyl, Xylazine					

Have you ever been treated for alcohol/drug use? _____ No _____ Yes Outpatient Residential Detox

PRIOR ASSESSMENT

Have you ever had any of the following evaluations:

- Neurological Psychological Substance Abuse ADHD/Learning Disabilities Other: _____

FAMILY MEDICAL HISTORY (please state condition & which relative has/had the following)

TYPE OF ILLNESS	PLEASE SPECIFY	RELATIONSHIP OF PERSON WHO HAD/HAS CONDITION
Alcohol/Drug Addiction		
Cancer/Tumor		
Diabetes		
Epilepsy/Seizure Disorder		
Heart Disease		
Mental Health (Depression, Anxiety, ADHD, etc)		
Autism Spectrum		
Other		

Have you ever *experienced* or *witnessed* domestic violence recently or in the past? _____

Have you ever *experienced* or *witnessed* traumatic events, recently or in the past? _____

Have you experienced any significant losses? (Such as; divorce/relationship loss, job loss, housing loss, permanent injury/loss of mobility, extended separation from primary caregivers in childhood, pregnancy loss, extended separation from child or other family member, estrangement from or death of friends/relatives/pets, etc.) _____ no _____ yes
If yes, please explain:

For office use only:	Date:	Signature:
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