Counseling Center at Concord

NAME _____ TODAY'S DATE _____

ADDRESS_____CITY_____STATE____ZIP____

DOB___/___/___ SEX: MALE/FEMALE

HOME PHONE#_____ WORK#_____ EMAIL: _____

PHONE NUMBER YOU PREFER US TO CONTACT YOU AT _____

EMPLOYER_____OCCUPATION_____

SPOUSE NAME _____

ADDRESS_____CITY_____STATE____ZIP____

DOB___/___/___ SEX: MALE/FEMALE

LOCAL CHURCH ATTENDING_____

PERSONAL PHYSICIAN_____

PREVIOUS COUNSELOR_____

CURRENT MEDICATIONS_____

IN EMERGENCY, PLEASE NOTIFY_____ PHONE#_____

HOW DID YOU HEAR ABOUT US? _____

Policy Holder's Information:

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S BIRTH DATE: _____

POLICY HOLDER'S EMPLOYER: _____

AUTHORIZATION# _____

OF SESSIONS AUTHORIZED: _____

Person Responsible for Bill: *(if different from above)*

NAME: _____

ADDRESS: _____

PHONE#: _____

Authorization To Pay Benefits to Practitioner and to Release Information.

I hereby authorize CC at Concord to release any information acquired in the course of my treatment necessary to process insurance claims and to submit claims for and receive any benefits for which I (or the patient) may be eligible for services rendered by the practitioner, realizing I am responsible to pay non-covered services.

_____

SIGNATURE (CLIENT OR PARENT IF MINOR)

Notice of Privacy Practice:

DURING THIS INITIAL CONTACT WITH YOU, WE WANT TO NOTIFY YOU OF CONFIDENTIALITY AND PRIVACY ISSUES. THESE PRACTICES ARE DESIGNED TO PROTECT YOUR INDIVIDUAL INFORMATION AND CONFIDENTIALITY. ALTHOUGH WE HAVE NOTIFIED YOU WITH OUR PRIVACY AND CONFIDENTIALITY PRACTICES, WE WILL GIVE YOU A WRITTEN COPY OF OUR **NOTICE OF PRIVACY PRACTICES** IF YOU REQUEST. THE WRITTEN **NOTICE OF PRIVACY PRACTICES** OUTLINES HOW WE CAN USE AND DISCLOSE INFORMATION ALONG WITH THE RIGHTS THAT YOU HAVE REGARDING YOUR INFORMATION MAINTAINED BY US.

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Also, we must obtain written acknowledgement that we have notified you of our privacy practices with you. By signing this form, you are only acknowledging that you have been informed about our practices to maintain privacy and confidentiality, and have read the **Notice of Privacy Practices.**

Charges and Payment Information:

The standard charge for a session (60 minutes) is $135.00 for Initial Intake ($125.00 for each visit afterward). In some situations where the standard fee would cause a severe financial hardship, clients may apply for reduced charges. Client assistance funds come from donations from individuals, churches, and businesses.

We have contractual adjustments with different sponsoring organizations which allow for adjusted fees. Your fee will be discussed with your counselor. Anytime you have financial questions, please discuss them with your counselor.

Cancellations and Missed appointments: Clients are requested to give a minimum 24 hour notice to cancel appointments. Appointments cancelled with less than 24 hours' notice or appointments missed are subject to a charge.

Insurance Coverage:

The center will assist you in filing for insurance benefits for covered services. If you intend to apply for insurance coverage, please present insurance policy information or a current insurance identification card at the reception area prior to your session. A photocopy of your insurance information will be made to assure that eligibility of coverage can be verified and that accurate claims can be filed. Full standard fee of $125.00 ($135 initial visit) must be charged when billing all insurance companies.

I authorize the release of any medical information necessary to process insurance claims filed on my behalf. I hereby assign payment of insurance benefits to the counseling center. I acknowledge that I am financially and legally responsible for the payment of services rendered whether my health insurance covers services rendered or not.

I have read and understand the center's policy on Notice of Privacy Practices, charges, insurance billing, cancellations and missed appointments. I agree and accept financial responsibility for payment and services rendered. I have read and been informed about how my privacy confidentiality will be maintained by the Counseling Center @ Concord.

X_____Date_____

Client/Responsible Party

Updated: 4/10/17

Payment Method

Please select *ONE* of the following methods of payment.

1. Co-Payment Method

I will pay the amount of co-payment or percentage agreed by my Insurance Company.
This amount is $_____ per visit.

_____

Client or Authorized Person Signature Date

2. Cash Payment Plan

I will pay 100% of the fee at the time that services are rendered.

_____

Client or Authorized Person Signature Date

3. EAP (Employee Assistance Plan)

I have authorization through my EAP (Employment Assistance Plan) and therefore, claims should be submitted directly to my EAP plan for payment.

_____

Client or Authorized Person Signature Date

4. Reduced Fee (for qualifying Individuals)

I will pay $_____ for each session as the entire fee for services. My insurance company will NOT be billed and no insurance claim will be provided.

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_____

Client or Authorized Person Signature Date

Updated: 4/10/17