Counseling Center at Concord

NAME OF CHILD _____ DOB___/___/___
ADDRESS WHERE CHILD RESIDES _____ CITY_____ STATE____ ZIP_____
LIST NAMES AND AGES OF SIBLINGS _____
HAS CHILD EVER BEEN IN COUNSELING BEFORE? YES NO WHEN? _____
REASON _____
WHAT ISSUES DO YOU WISH YOUR CHILD TO DISCUSS AND ADDRESS IN COUNSELING AT THIS TIME?
_____
SCHOOL CHILD ATTENDS_____ GRADE_____
CHILD'S PHYSICIAN _____ PHONE# _____
CURRENT MEDICATIONS _____

PARENT/ LEGAL GUARDIAN INFORMATION:

NAME OF FATHER _____DATE OF BIRTH _____
ADDRESS_____CITY_____STATE____ZIP____
PHONE # _____
EMPLOYER _____ PHONE# _____

NAME OF MOTHER _____DATE OF BIRTH __/__/_____
ADDRESS_____CITY_____STATE____ZIP____
PHONE # _____
EMPLOYER _____ PHONE# _____

IS THERE A CUSTODY ORDER IN EXISTENCE? __ YES __ NO
IF YES, WHO IS THE PRIMARY CUSTODIAN? _____ _____
ARRANGEMENTS? _____

HAVE YOU EVER BEEN INVESTIGATED BY CHILD PROTECTIVE SERVICES OR DEPARTMENT OF SOCIAL SERVICES?
IF YES, PLEASE SHARE DETAILS: _____

LOCAL PREFERENCE OR RELIGIOUS PREFERENCE _____
HOW DID YOU HEAR ABOUT OUR OFFICE? _____

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)

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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.

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