8025 North Point Blvd., Suite 231, Winston Salem, NC 27106 Voice: 336-896-0065 Fax: 336-896-0710
E-mail: info@christiancounseling.org www.ChristianCounseling.org

NOTE: If the client (patient) is under 18 years of age, this form must be completed and signed by a parent or legal guardian.

Client Name (Last, First, Initial) _____

Address_____ City/State _____ Zip _____

Birth Date _____ Male _____ Female _____ Employed _____ Student, Full or Part-time _____

Marital Status: Single _____ Married _____ Other _____

NOTE: In providing cell phone number(s) you acknowledge that you are aware that a cell phone is <u>not</u> a secure and private line.

Phone numbers we may use: Cell _____ Home _____ Work _____Other_____

In what order should we use them? _____ _____ _____ _____

May we leave a recorded message? _____ _____ _____ _____

May we leave a live message? _____ _____ _____ _____

If so, with whom? _____ _____ _____ _____

List the family members or other persons, if any, with whom we may speak or leave a message about your appointments: _____

List the family members or significant others, if any, whom we may inform about your condition ONLY IN AN EMERGENCY: Name _____ Phone Number _____

Name Phone Number

NOTE: It is our policy to mark all correspondence "Confidential".

Clearly print the address, <u>if other than your home,</u> where you would like your billing statements and / or correspondence from our office sent: _____

Are you currently under the care of a physician? _____ Name of physician _____

May we notify your physician we are treating you? Yes ____ No ____ If "Yes" initial here: _____

Physician's address and phone number _____

Name of person who referred you _____

(Circle one) ACC Client Counselor Doctor Friend Minister Attorney Other _____

May we thank them for referring you? Yes _____ No _____ If "Yes" initial here: _____

Address and phone number _____

Client's (patient's) relationship to insured: Self____ Spouse ____ Child ____ Other _____

If "Self" you may skip to "Primary Insured's Employer" in the next section.

Name (Last, First, Initial) _____

Address_____ City/State _____ Zip _____

Birth Date _____ Male _____ Female _____

Primary Insured's Employer _____

Primary Insurance _____

Primary ID No._____ Group No._____

Secondary Insurance _____

Secondary ID No. _____ Group No. _____

PATIENT'S, INSURED'S, OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any medical or other information necessary to process all claims for the client described above. I also request and assign payment of insurance, medical, and / or government benefits to Associates in Christian Counseling.

Signature Date

OFFICE STAFF ONLY: SUPPORT STAFF_____ CLINICIAN_____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, we offer an application to the Client Assistance Program.]

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, ID or Social Security number, address and phone number(s), the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

REGARDING INFORMATION WE ARE REQUIRED TO SHARE WITH YOUR INSURANCE COMPANY

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. You may request a copy of any report we submit. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

MANAGED CARE, HMOs AND PPOs

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.]

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. As a courtesy ACC will contact your insurance company and request a general description of mental health benefits. As ACC must rely on the information provided by the insurance company we cannot and do not guarantee or warrant the accuracy of that information. Also as a courtesy, we will fill out claims and other forms, as needed, and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we are willing to call the company on your behalf.

PSYCHOTHERAPY SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. Signature: _____ Date _____

OFFICE STAFF ONLY: SUPPORT STAFF_____ CLINICIAN_____