ADULT CLIENT INFORMATION FORM

Name: _____ E-Mail address: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone/Pager: _____

Date of Birth: _____ Age: ___ Social Security #: _____

Employer: _____ Work Phone: _____

Please indicate which number you prefer us to call to remind you of appointments: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Name of Spouse: _____ Age: _____

Spouse's Employment: _____ DOB: _____

Person Responsible for Payment: _____

(If other than Patient)

Address: _____

Home Phone: _____ Work Phone: _____

List Children's Names and Ages:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Please give your insurance information and your insurance card to the front desk.

INSURANCE POLICY HOLDER: _____ DOB: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Who referred you to our office? _____

Church Affiliation: _____ Pastor: _____

I authorize payment of medical benefits directly to the therapist, realizing that I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers. I understand that once StressCare releases information to an insurance carrier, StressCare has no control over how this information is handled by them.

Client's Signature: _____ Date: _____

PLEASE TURN OVER

CLIENT HISTORY

1. Have you ever been in any type of counseling before? _____

2. Have you ever been hospitalized for any type of mental health problems? If so, please give date and location:

   _____

   _____

3. Is there a history of alcohol and/or drug abuse or mental illness in your family? If yes, please explain:

   _____

   _____

4. Do you have a history of medical problems? Please list. _____

   _____

   _____

5. Are you currently taking medication? _____ Yes _____ No

   Name of medication: _____ Dosage: _____

   Prescribed by: _____ Start Date: _____

   Name of medication: _____ Dosage: _____

   Prescribed by: _____ Start Date: _____

   Name of medication: _____ Dosage: _____

   Prescribed by: _____ Start Date: _____

6. Please list names of physicians who are currently treating you: _____

   _____

OFFICE POLICIES AND CLIENT CONSENT FORM

Welcome to StressCare, Inc. The following is a description of our general office policies and other information designed to help you understand the counseling services we provide. Please read carefully and let us know if you have any questions.

APPOINTMENTS AND FEES

General office hours are 9:00 to 5:00 Monday through Friday and clients are seen by appointment only. Some of our therapists offer evening appointments.

For a current list of fees and payment options, ask our office staff or call 706-552-0706, ext. 203. There will be a charge for all returned checks.

Payment is due when services are rendered. All co-pays/deductible fees must be paid at the time of service. Outstanding balances after ninety (90) days will be turned over to a collection agency.

INSURANCE

As a courtesy to our clients, we do accept and file claims for some insurance companies. However, it is your responsibility to be familiar with your insurance benefits and any requirements the insurance company may have. If you anticipate using insurance, you are required to check with your insurance company before attending your first session to determine if they cover outpatient counseling or psychological services. If you have not done this prior to your first session, you will have to pay the full fee until this matter is clarified. It is your responsibility to obtain pre-authorization if required by your insurance company. FAILURE TO OBTAIN REQUIRED AUTHORIZATION MAY RESULT IN NON PAYMENT OF YOUR CLAIMS. THEREFORE, YOU WILL BE BILLED FOR THAT DATE OF SERVICE. Clients are responsible for the portion of fees that insurance does not cover. The balance of your account is your responsibility whether your insurance company pays or not. We allow 90 days before we change the balance from INSURANCE responsible to PATIENT responsible. Your insurance is a contract between you and your insurance company. We will be happy to help you by providing receipts, but we will expect payment for services rendered.

Not all of our counselors are contracted providers for all insurance companies Please consult your insurance company regarding the counselor you are seeing to determine if he or she is a contracted provider. If your counselor is not a contracted provider with your insurance company, you will be required to pay for your sessions and file for reimbursement yourself.

TELEPHONE CONSULTATIONS AND EMERGENCIES

It is understood that from time to time, you may need to consult with one of the therapists briefly by telephone. For these necessary and brief consultations, there is no charge. However, if you wish further assistance, we can schedule an additional session or we can proceed with our phone session, for which you will be charged at the regular fee on a pro-rated basis after the first five minutes. In the event of any emergency, each therapist has their method of providing emergency care. It is your responsibility to ask your therapist about their method.

CHILDREN

Our goal is to provide a quiet, relaxed atmosphere for our clients during counseling and evaluation sessions. In consideration of other clients who are in session at the time, we ask that children who must come to the office be as quiet as possible while waiting. It is the responsibility of the parent or guardian for <u>any children</u> brought into the counseling office to be <u>supervised by an adult in the waiting area</u>. *Parents are strongly encouraged to leave children not directly involved in counseling sessions at home.*

COUNSELING FOR CHILDREN

The parent or guardian bringing a minor child in for counseling or evaluation services is responsible for payment of fees or any co-payment. In the event that the parents of the child are divorced and must each pay half of any medical bills, the parent bringing the child must pay the full amount due for services at the time of service. Upon request, receipts will be given to provide proof of payment.

PLEASE NOTE: If the parents of a minor child are divorced, information regarding the child and the counseling process can only legally be given to the parent who has legal custody of the child. Information concerning the minor child may be shared with both parents if the parents have joint legal custody of the child.

INFORMED CONSENT

Counseling may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness or helplessness may also be aroused.

The benefit from counseling may be that you will be better able to handle or cope with your family or social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to a greater maturity and growth as a person.

You should know that therapists are not physicians and cannot prescribe or provide you with any drugs or medication or perform medical procedures. If medical treatment is indicated, a physician can be recommended for you.

CONFIDENTIALITY POLICY

Confidentiality is one of our main concerns in the practice of counseling and psychotherapy. For your protection, information about counseling and your records are held strictly confidential and cannot be discussed or released to anyone without

your written consent. You will be asked to sign a release should it be necessary for StressCare staff to discuss you or your child's case with another party. The exceptions to this policy are noted below:

- **Disclosures to family members, the police, social service agencies and others may be made when there is sufficient cause to believe that you pose an imminent threat of physical harm to yourself or others.**
- **If there is a life-threatening emergency, necessary information will be released to family, law enforcement officials, other treatment professionals or hospitals in order to avoid loss of life.**
- **Mental health professionals are required by law to report to State officials any suspicion of abuse or neglect to a minor child, disabled or elderly person. Information necessary to make this report will be released in that event.**
- **If you have been Court ordered to our office for an evaluation, information will be released to the Court and to the attorneys in the case, as required by law. However, you will be asked to sign appropriate releases so that you will be informed to whom information will be sent.**

The Health Insurance Portability and Accountability Act (HIPAA) provides additional safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years.

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. **Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. Client files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, client records, PHI and other documents or information.**
2. **We will make all reasonable efforts to protect your privacy. Secure and private communications cannot be fully assured when utilizing many electronic technologies. You can choose to agree to hold harmless your therapist or any other StressCare staff when communication between you and them is conducted via any non-secured electronic device or means,**

including but not limited to e-mails, text messaging and cell phones. You can also choose to request that no non-secured modes of communication be utilized. Please check one:

__ I agree to the use of non-secure modes of communication.

__ I do not agree to the use of non-secure modes of communication and ask to only be contacted via wire to wire phone, wire to wire fax or US Mail.

3. **The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. One of these vendors is our electronic billing service.**
4. **You understand and agree to the inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties**
5. **You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or your therapist.**
6. **Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.**
7. **We agree to provide patients with access to their records in accordance with state and federal laws.**
8. **We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.**
9. **You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.**

If you have any questions regarding the information above, feel free to ask your therapist for clarification.

TERMINATION POLICY

Termination notes will be placed in each patient's file and these notes will reflect both the reason for the termination, as well as whether it was a mutual or unilateral decision on the part of the client. If you request further treatment, a recommendation will be made to direct you to three other local practitioners for follow-up care.

Any unpaid balance owing at the termination of counseling will be the responsibility of the client.

I do hereby consent and acknowledge my agreement to the terms set forth. I understand that this consent shall remain in force from this time forward.

Client's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

MISSED APPOINTMENT POLICIES

We value your time and participation in the counseling process. We want your counseling experience to be positive and helpful in all ways. Counseling is most effective when appointments are kept consistently. It is our pledge to meet with you for your appointment in as timely a manner as is possible and we expect for you to make all reasonable efforts to attend your appointments and to be on time.

When you schedule your appointment, you have reserved this time in our schedule and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 706-552-0706 **at least 24 hours in advance.** This will allow our staff to contact clients on our waiting list and to offer them this appointment time. At some point in your counseling process you may be the beneficiary of such a fill-in appointment.

If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits, you will be charged our pay-in-full missed appointment fee of $75.00.

The only exceptions to this policy are appointments missed due to last minute illness or emergencies. You should note that insurance companies do not reimburse members for such charges.

You will be billed directly for missed appointments. Payment for missed appointments is due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay this fee at the time you check in for your next appointment.

As a courtesy, our staff will try and call you the working day before your next appointment to help remind you to attend. **However, this is a courtesy call only.** You are still responsible for remembering your appointment and attending. Not receiving this call or receiving it after the 24 hour time limit does not excuse you of this responsibility.

Thank you for taking time to review our missed appointment policies. We hope making them very clear will eliminate any possible misunderstanding if they need to be applied during your counseling process. By signing below you are indicating that you have read, understood, and agree to these conditions.

Client Signature:_____ Date:_____

Witness:_____ Date:_____

Patient Name: _____

Therapist: _____

Dear Patient:

Insurance companies offer a wide variety of plans, some of which require patients to use designated (in-network) physicians or other health care providers. Some plans also require pre-approval or authorization, particularly for mental health services, before such services will be covered. Also, benefits and co-pays for mental health services tend to differ from benefits and co-pays for typical health related services.

We want to make you aware that it is your responsibility to understand your insurance coverage, make certain you are using "in-network" mental health providers and to obtain authorization requirements before services for counseling are received. You should also be aware of the co-pays and deductibles associated with your mental health benefits.

***To ensure you receive your maximum benefit from insurance, we encourage you to review your plan and contact your carrier if you have any questions concerning healthcare coverage*.**

If the therapists at StressCare do not participate with your insurance company or do not contract with your insurance company, you will be expected to pay in full at the time services are rendered, including your first visit.

If pre-authorization is required by your insurance company, and you have not obtained such authorization prior to your first visit, you will be asked to make a phone call from our office to obtain authorization prior to being seen by your therapist.

Please let us know if you have any questions.

_____ _____

Date *Signature of Patient or Responsible Party*

_____ _____

Date *Witness*