StressCare

Date ____________

CHILD & ADOLESCENT CLIENT INFORMATION FORM

Child's Full Name ____________________________ Nickname ________________ Male ___ Female ___

Date of Birth ________________ Age ____ Grade _______ School ______________________________

Parent/Guardian Phone ________________________ Email ____________________________________

Address _______________________________ City____________________ State ____ Zip ___________

Please indicate the best phone number to call to remind you of appointments _______________________

We will make all reasonable efforts to protect your privacy. Secure and private communications cannot be fully assured when using many electronic technologies. For your convenience in communicating, you can choose to agree to hold harmless your therapist and the office staff when communication is conducted by any non-secure electronic device (including but not limited to e-mails, text messaging and cell phone calls). You can also choose to request that no non-secure modes of communication be used. ***PLEASE INITIAL ONE:***

_____ I agree to the use of non-secure modes of communication (examples: calls to or from my cell phone, text message or email appointment reminders, etc.)

_____ 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. ***NOTE:*** *By choosing this option* ***you will not receive reminders for upcoming appointments.***

Person Responsible for Payment if other than Client ____

Name of Insurance Policy Holder _________________________ **Insurance Company** _________________

Policy Holder Date of Birth _________________ Relationship of Policy Holder _______________________

Address of Policy Holder _____________________City _________ State ___ Zip _____ Phone # __________

Biological parents of child are (circle one): Married Divorced Separated Single Parent

Mother's Information:

Name ___________________________________

Date of Birth ____________________ Age _______

Address ________________________________

City, State, Zip ____________________________

Home Phone _____________________________

Cell Phone ______________________________

Employment _____________________________

Work Phone _____________________________

Father's Information:

Name ___________________________________

Date of Birth ____________________ Age _______

Address ________________________________

City, State, Zip ____________________________

Home Phone _____________________________

Cell Phone ______________________________

Employment _____________________________

Work Phone _____________________________

If parents are divorced, please specify who has custody ____

Child lives with ___________________________ (ie, mother & father, father & step-mother, grandparents, etc)

Is child adopted? YES _________ NO _________ If yes, at what age? ____________________________

(Flip page and continue)

Names of Siblings:

Name ______________________________ Age ______ Name ______________________________ Age ______

Name ______________________________ Age ______ Name ______________________________ Age ______

CHILD'S HISTORY

1. Has the child ever been in any type of counseling before? If yes, with who and for what reason?

2. Has the child 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 the child's family? If yes, please explain:

4. Does the child have a history of medical problems? Please list:

5. Is the child currently taking medication? _____Yes _____No If yes please list below:

Name of Medication	**Dosage**	**Prescribed by**	**Start Date**

6. Please list names of physicians who are currently treating the child:

If necessary, to whom would you like for us to release your child's personal health information?

Name ________________________________ Phone Number ________________ Relationship ____________________

Emergency Contact ________________________ Phone Number ______________ Relationship __________________

Who referred you to our office? ____

Church Affiliation ____________________________________ Pastor ___________________________________

<u>STRESSCARE OFFICE POLICIES</u>

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

General office hours are 9:00 to 5:00 Monday through Friday and clients are seen by appointment only. Call the front office at (706) 552-0706 ext. 203 to schedule appointments or schedule them at the office on the day of your appointment. Some late afternoon/evening appointments may be offered.

PAYMENT

Payment is due at the time of your appointment. This includes all <u>copays</u> and <u>deductible fees</u>. For current fees check with your insurance company prior to your appointment and ask our office staff upon arrival. All of our therapists accept cash and checks. Please ask the office staff if your therapist also accepts Credit/Debit/Flex Spending cards. There will be a charge for all returned checks. 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, mental health or behavioral health 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.**

Please consult your insurance company to confirm that your counselor 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. It is your responsibility to obtain pre-authorization if required by your insurance company.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. **FAILURE TO OBTAIN REQUIRED AUTHORIZATION MAY RESULT IN NON PAYMENT OF YOUR CLAIMS. THEREFORE, YOU WILL BE CHARGED FOR THAT DATE OF SERVICE**.

<u>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</u>. 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.

ASSIGNMENT OF BENEFITS

I release **Stresscare** to bill medicaid, medicare, and/or my insurance on my behalf for all services received. I hereby authorize my Medicare/Medicaid and/or medical insurance benefits to be paid directly to **Stresscare**. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf. I understand that if my claim is denied or my coverage lapses I am responsible for the full cost of the services provided by **Stresscare**.

CANCELLATIONS AND MISSED APPOINTMENT POLICIES

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. **<u>If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limit, you will be charged a missed appointment fee of $75.00.</u>** The only exceptions to this policy are appointments missed due to last minute illness or emergencies. You should note that insurance companies do not pay providers or reimburse members for missed appointment fees.

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, text or email (with your consent) you the working day before your next appointment to help remind you to attend. <u>However, this is a courtesy call only.</u> 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.

TELEPHONE CONSULTATIONS AND EMERGENCIES

From time to time, you may need to consult with your therapist briefly by telephone. For these necessary and brief consultations, there is no charge. However, if you desire 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. **This is an outpatient counseling practice that does not provide emergency care. In the event of any emergency, call 911 or go to the nearest emergency room.**

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. **It is the responsibility of the parents to agree upon the counseling process for the child before bringing the child to counseling.** By signing this document you are acknowledging that you have the legal rights to seek counseling for your child and you release StressCare Counseling from liability in this matter.

INFORMED CONSENT TO TREATMENT

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 AND NOTICE OF PRIVACY POLICIES

Confidentiality is one of our main concerns in the practice of counseling. 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 your counselor and/or 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, including a Summary of the HIPAA Rule, is available from the United States Department of Health and Human Resources Summary. www.hhs.gov

StressCare has adopted the following Privacy Practices:

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. 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.
3. 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-secure modes of communication be used on the first page of the client information form.
4. 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.
5. 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
6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or your therapist.
7. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
10. 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 or a complaint about how your PHI is handled here or regarding the information above, feel free to speak with your therapist. If unresolved, complaints can be made to the U.S. Department of Health and Human Services.

By signing below I am indicating that I have read, understand, and agree to adhere to all of the StressCare Office Policies, Informed Consent Information and StressCare Privacy Practices. If I have questions, they have been answered. I consent to these policies and to receiving counseling from this counselor. By signing below I am affirming that I and/or my child are the ones receiving counseling from Stresscare and I have the appropriate legal rights/guardianship/custody to consent to counseling for myself or this minor (if signing for a minor). I affirm that the information I have provided above is true and accurate to the best of my knowledge.

Signature of Client or Responsible Party ______________________________ **Date** ____________