SUPPORT UNDERSTANDING GROWTH

Foundations Counseling Center

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Client Name: _____
First Middle Last

Street Address: _____
Number Street City State Zip Code

Home Phone: _____ **Cell/Other Phone:** _____**Work:** _____

E-mail Address: (For appt. reminders and billing purposes only) _____

Date of Birth: _____ **Social Security #:** _____

Sex: (M) _____ (F) _____ **Marital Status:** Single Married Widowed Divorced

Is the client a full time student? YES NO **Is the client employed?** YES NO

School and level of education: _____ **Name of Employer:** _____

Referral Source: _____

If client is a minor (under age 21), please fill out information below: {otherwise, skip to next section (**)}

MOTHER

Name: _____

DOB: _____

Address: _____

_____

Phone: (H)_____ **(C)** _____

Education: _____

Occupation: _____

Employer: _____

FATHER

Name: _____

DOB: _____

Address: _____

_____

Telephone: (H) _____**(C)** _____

Education: _____

Occupation: _____

Employer: _____

** **PERSON RESPONSIBLE FOR CLIENT'S ACCOUNT:** _____

Relationship to Client: _____ **Phone:** _____

Address: _____

SS# _____**Date of Birth:** _____

Name of Employer: _____ **Occupation**: _____

** Person responsible for client account must provide signature on following page**

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance: _____

Policy/Member/Recipient #: _____ Group#:_____

Name of Policy Holder/Insured: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Insured's SSN: _____ Insured's Employer: _____

FINANCIAL AGREEMENT

1) **ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT OR PATIENT'S GUARANTOR REGARDLESS OF INSURANCE COVERAGE.**
2) **Only primary insurance policies are accepted.**
3) **I understand that I will be responsible for all co-pays, co-insurance, and deductibles of the primary insurance at the time of my visit.**
4) **I understand that appointments not cancelled by 24-hour prior notice will be charged a no-show/same day cancellation fee of $75.00.**
5) **I understand a fee of $25.00 will be charged to me for each check returned due to any reason, such as insufficient funds.**
6) **I understand that there is a minimum charge of $15.00 for the disbursement of medical records. Charges may exceed $15.00 in the event that the cost of copies and shipping are greater than $15.00. The total charge must be paid before medical records are released.**
7) **I understand that a fee of $100.00 will be charged for the completion of forms and letters of any type. Each provider of services reserves the right to decline to complete any form or letter.**
8) **In the event of collection proceedings, I agree to pay any and all collection and/or interest fees that may be added to my account to recover monies due to my provider of service.**
9) **I understand that the charges mentioned above (items 3, 4, 5, 6, 7, 8) are not billed to the insurance company and are the sole responsibility of the patient/responsible party. I further understand that should I have any such outstanding charges to my account these charges must be paid before my next appointment will be scheduled.**
10) **I authorize the release of medical or other information necessary to process my insurance claims.**
11) **I authorize payment of all claims directly to the provider of services.**

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND AGREE TO THE GUIDELINES LISTED ABOVE.

_____ _____ _____

Signature of Patient or Responsible Party **Print Name** **Date**

PATIENT CONSENT FORM

The Notice of Privacy Practices provides information about how Foundations Counseling Center may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent. The term of the Notice may change. If changed, you may obtain a revised copy by contacting asking your provider of services.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. Foundations Counseling Center is not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to the use and disclosure of protected health information about you for the purpose of treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures Foundations Counseling Center has already made in reliance from your prior consent. Foundations Counseling Center provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In summary, the patient/patient's guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Foundations Counseling Center has a Notice of Privacy Practices and the patient/patient's guardian has the opportunity to review this Notice.
- Foundations Counseling Center reserves the right to change the Notice of Privacy Policies.
- The patient/patient's guardian has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Foundations Counseling Center may condition treatment upon the execution of this Consent.

_____ _____

Signature of Patient or Patient's Guardian **Printed Name of Patient or Patient's Guardian**

_____ _____

Relationship to Patient **Date**

_____ _____

Signature of Practice Representative **Date**