



# Foundations Counseling Center

**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**

**FATHER**

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone: (H)** \_\_\_\_\_ **(C)** \_\_\_\_\_

**Telephone: (H)** \_\_\_\_\_ **(C)** \_\_\_\_\_

**Education:** \_\_\_\_\_

**Education:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**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 \$115.00 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/patient's guardian has the right to file a formal grievance for any perceived violation of their patient rights or standard of care.
- 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

## ELECTRONIC MAIL/TEXT MESSAGING COMMUNICATION INFORMED CONSENT FORM

Foundations Counseling Center and its associates (at their own discretion) may choose to communicate with their patients (or the guardians of their patients in the case of minors) regarding scheduling/rescheduling/canceling appointments only.

### Conditions for the use of electronic mail (e-mail) and text messaging:

Foundations Counseling Center and its associates cannot guarantee but will use reasonable means to maintain security and the confidentiality of information transmitted and received via e-mail and text messaging. Foundations Counseling Center and its associates are not liable for improper disclosure of confidential information that is not the result of a provider's intentional misconduct. The following are the conditions to which electronic mail and/or text messaging will be used:

- E-mail and/or text messaging will ONLY be used for the purpose of scheduling, rescheduling, and canceling appointments.
- Communicating via e-mail and text messaging is not appropriate for urgent or emergency situations.
- Foundations Counseling Center and its associates cannot guarantee that any particular e-mail and/or text message will be read and/or responded to within any particular time.
- All e-mails and text messages should be concise.
- There will be NO communication about complex and/or sensitive situations or medical information sent via e-mail or text messaging. Any such discussion must occur in person by appointment only.
- All e-mails and text messages will be printed and filed into the patient's medical record.
- Foundations Counseling Center and its associates will not forward patient's (or in the case of a minor, the legal guardian's) identifiable e-mails or text messages without the patient's (or legal guardian's in the case of a minor) written consent, except as authorized by law.
- Foundations Counseling Center and its associates are not liable for breaches of confidentiality caused by a patient or any third party.
- It is the patient's (or in the case of a minor, the legal guardian's) responsibility to follow-up and/or schedule appointments if warranted.

### Risks of electronic mail (E-mail) and text messaging communication:

The transmission of patient information by e-mail and/or texting has several risks that patients should consider prior to the use of e-mail/texting communication. These include but are not limited to the following risks:

- Information communicated through e-mail and text messaging can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Users of e-mail and text messaging can easily misaddress an e-mail or enter the wrong phone number for text messaging and send the information to unintended recipients.
- Back-up copies of e-mails and text messaging may exist even after the sender and/or recipient has deleted his or her copy.
- Employers and internet companies have a right to inspect e-mails sent through their servers.
- E-mail and text messages can be intercepted, altered, forwarded, or used without authorization or detection.
- Information sent via e-mail and text messaging can be used as evidence in court.
- Communication via e-mail and text messaging may not be secure and it is possible that a third party may breach the confidentiality of such communication.

### Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail and text messaging.

—— I consent to the conditions and instructions outlined above with regards to communicating via e-mail and text messaging with Foundations Counseling Center and its associates.

—— I decline permission to communicate via e-mail or text messaging with Foundations Counseling Center and its associates.

\_\_\_\_\_  
Signature of Patient or Patient's Guardian

\_\_\_\_\_  
Printed Name of Patient or Patient's Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Practice Representative

\_\_\_\_\_  
Date