Counseling and Health Center, LLP ♦ 616 E. Bloomington St. Iowa City, IA 52245
Phone: (319) 337-6998 ♦ Fax: (319) 354-1679

Client Information Form

PERSONAL INFORMATION

Last Name_____First Name_____MI_____ Sex: □Male □Female

Date of Birth___/___/_____ SSN_____ Marital Status: □Single □Married □Other

Address_____City, State_____Zip Code_____

Employment Status: □Employed □FT Student □PT Student □Other

May we leave a message at the following numbers?

Cell Phone_____□Y □N Would you like text message appointment reminders? □Y □N

Home Phone_____□Y □N Work Phone_____□Y □N

Email Address_____ Would you like email appointment reminders? □Y □N

May we send your statements via email? □Y □N

Primary Care Provider_____

How did you hear about us? □Yellowbook □Dex □Website □Referral □Other

INSURANCE INFORMATION

Insurance Company_____

Insurance ID #_____

Relationship to Policy Holder □Self □Spouse □Child □Other

If you are not the primary policy holder, please fill out the information below.

Policy Holder's Name_____Date of Birth_____/_____/_____

Policy Holder's Address_____City, State_____

Zip Code_____Phone_____

The patient/responsible party is hereby responsible for charges incurred during the course of treatment. Counseling and Health Center, LLP, will, as a service to the patient, file claims with the insured carrier(s) listed above. Any charges not covered by the carrier(s) will be the responsibility of the patient/responsible party. I hereby authorize the practitioner to release all information necessary to secure payments of benefits from the insurance carrier(s) listed. I authorize the payment of medical benefits to Counseling and Health Center, LLP for services rendered. I authorize Counseling and Health Center, LLP to release any psychological, mental health, and/or drug/alcohol abuse information to my health insurance company for the purpose of billing and pre-certification. I understand that this authorization continues indefinitely until I rescind it in writing.

_____

Client Signature (If client is under age 18 parent or guardian must sign) Date

For Office Use Only

Provider_____Client ID_____Diagnosis_____

Copay _____Coinsurance_____# Annual Visits_____Pre-Auth: □Yes □No

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Client Informed Consent

This document is an agreement between you (responsible adult), _____ and Counseling and Health Center, LLP (CHC). When we use the words "you", "your", and "yourself" below it will mean your child, relative, or other person receiving treatment if you have written his or her name here _____.

By signing this form you are agreeing to let us use your information as described in the Notice of Privacy Practices. The Notice of Privacy Practices explains in more detail your rights and how we may use or share your protected health information, including requirements of disclosure by law. Please read the Notice of Privacy Practices before signing this form. **If you do not sign this form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.**

There is no assurance that you will feel better after engaging in therapy. Some material that may come up in therapy sessions could be upsetting to you, and it may be part of a necessary process for resolving your problems. Additionally, your insurance company may require that your records be reviewed by another provider for the purposes of supervision.

You have the:

- **right** to be informed of the steps and activities involved in receiving services
- **right** to confidentiality according to state and federal laws
- **right** to humane care and protection from harm, abuses, or neglect from the staff
- **right** to make an informed decision whether to accept or refuse treatment

- **responsibility** to disclose full information about yourself in order to receive proper care
- **responsibility** to work with your therapist in developing goals and plans
- **responsibility** to follow the treatment plan and instructions for care
- **responsibility** to keep and pay for scheduled appointments or provide 24 hour advance notice of cancellation (see payment policy)

After you have signed this consent, you have the right to revoke it (by writing a letter telling CHC that you no longer consent) and we will comply with your wishes about using or sharing your information from that time on; however we may already have used or shared some of your information and cannot change what has already been disclosed. If you do not choose to revoke your consent, it will automatically expire one (1) year after the end of treatment or after all claims for treatment have been paid according to provisions of your healthcare program or insurance plan.

_____ _____

Client Signature (If client is under age 18 parent or guardian must sign) Date

Acknowledgement of Receipt of Privacy Practices Notification

Check one option:

____ I have received the Notification of Privacy Practices from Counseling and Health Center, LLP as requested by law.

____I have been offered a copy of the Notification of Privacy Practices from Counseling and Health Center, LLP and have declined them.

_____ _____

Client Signature (If client is under age 18 parent or guardian must sign) Date

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Payment & Cancellation Policies

PAYMENT POLICY

Payments for services at the Counseling and Health Center are due at the time of service.

If you are using mental health benefits provided by your insurance coverage, you are responsible for any copayment or coinsurance. If you have not met the deductible required by your policy, you are responsible for all charges until the deductible has been met. Please read over your policy or contact your insurance carrier to determine deductible, copayment, and coinsurance amounts.

We bill insurance companies as a courtesy to our clients. At the end of **6** months, if your insurance company has not reimbursed this office for your care, we will bill you. It is your responsibility to confer with your insurance company to recover these fees.

Accounts over thirty (30) days old are due in full upon receipt of billing. You will need to contact your therapist directly to discuss payment and rescheduling options if your account is overdue.

I agree that I am responsible to pay all charges not paid by my insurance.

_____ _____

Signature (Parent or guardian if client is under age 18) Date

LATE CANCELLATION POLICY

Since we can accept only a limited number of clients, our time is precious. A late cancellation or missed appointment is a loss to us and to those waiting for appointments. If you need to cancel an appointment, we ask that you call **24** hours in advance of the appointment. Arriving more than 20 minutes late without prior notification or not coming at all constitutes a missed appointment.

The charge for a late cancellation or missed appointment is $50 for a 30 minute session, $70 for a 45 minute session, $90 for a 60 minute session, and $25 for an appointment with the nurse practitioner.

If you have insurance coverage, please be aware that your insurance company pays only for appointments that you keep.

You personally will be charged for missed appointments or appointments not cancelled 24 hours in advance.

I agree to pay for missed appointments or those not cancelled 24 hours in advance.

_____ _____

Signature (Parent or guardian if client is under 18) Date