

CLIENT INTAKE FORM

CLIENT INFORMATION

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER Home _____ Bus. _____ Cell _____

E-MAIL ADDRESS _____

SOCIAL SECURITY NUMBER _____

BIRTHDATE _____ MALE _____ FEMALE _____

REFERRED BY _____

PRIMARY CARE PHYSICIAN (NAME, PHONE NUMBER, AND ADDRESS)

RESPONSIBLE PARTY (if applicable)

PARENT/GUARDIAN _____

ADDRESS _____

TELEPHONE NUMBER Home _____ Bus. or Cell _____

SOCIAL SECURITY NUMBER _____

INSURANCE INFORMATION

MARITAL STATUS Single _____ Married _____ Divorced _____

EMPLOYMENT STATUS Employed _____ Student _____

NAME OF INSURED _____

BIRTHDATE OF INSURED _____

INSURED ID# _____ Group # _____

RELATION TO INSURED Self _____ Spouse _____ Child _____

NAME OF EMPLOYER _____ PHONE # _____

INSURANCE COMPANY NAME _____ PHONE # _____

INSURANCE COMPANY ADDRESS _____

I authorize the release of medical information necessary to process an insurance claim. I authorize payment of benefits to Clinical Counseling Associates, Inc. for services rendered. I understand that I am responsible for any charges not covered by my insurance plan. I understand that a statement of account will be sent monthly to keep me apprised of my account status and what amount I am responsible for. I understand that if I have any questions regarding my account, I may call the office for assistance.

SIGNED _____ DATE _____

Clinical Counseling Associates, Inc.; Adoption and Fertilities Resources
1129B W. Kansas, Liberty, Missouri 64068

Telephone Number: (816) 781-8550

Fax Number: (816) 792-3219

FEE AGREEMENT

PAYMENT POLICY

Clients should keep their appointment or call at least 24 hours in advance to cancel visits. If not, the client will be charged for the visit at 50% of the regular fee. (Insurance cannot be billed for a no show charge) The usual fee for professional services is \$130 for the initial visit and \$110 per 50-minute session thereafter. Payment will be due at the time service is rendered. We accept cash, check, credit card or debit card. _____ Please initial

If you wish, as a courtesy we will file insurance within five business days of your visit, however, insurance coverage is not a guarantee for payment. It is the client's responsibility to check with the insurance company regarding coverage and copayments. If the client provides documentation of coverage by a managed care plan with whom we have a contract, we will accept copayment of charges. _____ Please initial

Initial sessions for marriage and/or family counseling will be 1 hour, 50 min. sessions. The first hour of the session can be filed with insurance, if applicable. The second hour will be the client's responsibility. _____ Please initial

If a balance is on your account, a statement will be provided monthly. If a balance remains for more than 60 days, your account will be assessed a \$10 service charge. This charge will continue each month until your account is paid in full. _____ Please initial

There will be a \$30 charge for any check returned for insufficient funds, closed account, or for any other reason.
_____ Please initial

Phone consultations with clients, schools, doctor offices, attorneys, etc. can be provided for a \$25 fee per 15 minutes, if these phone consultations exceed 15 minutes. This will not be submitted to insurance. _____ Please initial

Letters to doctors, schools, attorneys, etc. can be provided for a fee of \$25. This will not be submitted to insurance. _____ Please initial

STATEMENT OF UNDERSTANDING

I have read the above payment policy and agree to abide by these policies. I understand that I am responsible for 100% of charges for services provided. I understand I am responsible to pay full fees for services at the time of each session. I understand that I am responsible for contacting my insurance company to confirm coverage and/or copayments. I understand that I must provide documentation of insurance coverage before the provider will agree to accept copayments. _____ Please initial

I hereby authorize the release of medical information necessary to process insurance claims. I authorize payment of benefits directly to Clinical Counseling Associates, Inc. for services rendered. If my insurance company sends me checks for payment of sessions, I agree to notify Clinical Counseling Associates, Inc. and sign over any checks to CCA as payment for any outstanding charges on my account. I understand that I am responsible for any charges on my account. I understand that a statement will be sent monthly to keep me informed of my account status. I understand that if I have any questions regarding my account, I may call the office for assistance. Please date and sign. Thank you.

Date _____ Signature _____

CLINICAL COUNSELING ASSOCIATES, INC.

LAURA K. PROBASCO, LCSW

1129B W. Kansas St.

Liberty, Missouri 64068

Phone: (816) 781-8550

Fax: (816) 792-3219

e-mail: cca144@sbcglobal.net

Please read the following information about our office policies. If you have any questions, please do not hesitate to ask.

COUNSELING SESSIONS AND CLIENT RIGHTS AND RESPONSIBILITIES

All counseling sessions are by appointment only. Sessions last approximately 50 minutes once a week. Sometimes it is necessary to meet more often initially to handle crisis situations. The frequency of counseling sessions will gradually decrease as progress is made in counseling. This will also depend on your insurance policy.

All clients will be treated by a licensed mental health professional with respect for their individual needs, preferences, feelings, and requirements. An individual treatment plan will be developed for each client. The client has the right to participate with the therapist in treatment planning decisions. If transfer or discharge of the patient from treatment becomes necessary, clients will be given the reasons and plan, as well as reasonable advance notice.

All clients are responsible for providing the therapist with all needed information to allow them to provide appropriate care, as well as being open and honest with their therapist. Clients should ask questions so that they understand the care and instructions they are given. They should actively participate in their own treatment and carry out therapeutic homework assignments.

CONFIDENTIALITY

Matters discussed with your therapist are protected by laws insuring your right to privacy. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then, only to the extent you authorize. Your treatment record and related financial records are kept in a file cabinet in an office, or other area not accessible to the public. Records will not be copies or otherwise made available to others, except as noted below, without a signed authorization to release information.

Those cases where information may be disclosed without your consent are:

- 1) Information required by insurance company to process a claim or obtain further clinical visits.
- 2) Where child abuse is known or suspected. (Reporting is required by State Law)
- 3) When the abuse of an elderly or dependent person is known or suspected. (Reporting is required by State Law)
- 4) If there is a situation that is potentially life threatening.
- 5) When ordered by the Court.
- 6) In some cases, details of your treatment may be discussed with a clinical supervisor or another clinician for the purpose of consultation. When this is done, no identifying information will be included (i.e., the client is anonymous)

Please initial that you have read and understand these policies. _____