

CLIENT INFORMATION

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Female  Male

Email Address: \_\_\_\_\_ Status: Single  Married  Other

Referred by: \_\_\_\_\_

Employment Status: Yes  No  Other  \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

2nd Insurance Provider: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Cash Rate quote (Client not using insurance): \_\_\_\_\_

EAP: \_\_\_\_\_ Authorization #: \_\_\_\_\_ # of visits: \_\_\_\_\_

Primary Care Physician address & phone: \_\_\_\_\_

Psychiatrist address & phone: \_\_\_\_\_

AUTHORIZATION FOR PAYMENT OF SERVICES

*I authorize the release of any medical or other information necessary to process any insurance claim. I authorize payment of medical benefits to Christian Counseling Associates of Western Pennsylvania for services rendered.*

Signature of Client/Subscriber \_\_\_\_\_ Date: \_\_\_\_\_

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FOR OFFICE USE ONLY

INSURANCE: Copay \_\_\_\_\_ Coinsurance % \_\_\_\_\_ Deductible \_\_\_\_\_ Met \_\_\_\_\_

CC Notes: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Counselor & Location:

Contacted & Emailed:

Coordinator & Date:



**Client Agreement for Counseling Services**

**Client rights and responsibilities**

Every client of Christian Counseling Associates (CCA) is entitled to:

- Participate in treatment decisions during his or her care.
- Be treated at all times with dignity and respect by counselors and staff.
- Voice a complaint or appeal a decision about care provided.

Every client being treated by CCA has a responsibility to:

- Provide information the counselor needs to give appropriate care.
- Follow the counselor’s recommended plans and instructions for care.
- Participate in the treatment process through a focus on problems and the development of mutually agreed upon treatment plans and goals.
- Inform the staff of any changes in your health insurance coverage.
- Keep scheduled appointment and comply with your insurance provider’s cancellation policy.

**Privacy and Confidentiality**

Your medical records are protected from disclosure under both state and federal laws relating to mental health services. Conversations and test results are held in strict confidence unless otherwise provided for by state or federal regulations such as: You are a danger to yourself or to others, or a child is endangered. If your counselor needs to consult with someone regarding your treatment, you will be asked to sign a release form that will clearly identify the information to be exchanged, the parties involved in the exchange, and the reason for the communication.

**Fees and payments**

Initial Evaluation:	\$150.00
Psychotherapy (55 – 60 Min.):	\$125.00
Cash Rate/Sliding Scale Fee:	\$_____
Counselors Initials:	_____

**PLEASE NOTE:** All amounts quoted regarding your insurance benefits are good faith ESTIMATES. We do try our hardest to give you an accurate estimate of your financial portion (i.e. deductible and copay amounts, and eligibility of insurance coverage). Ultimately, the client is responsible for knowing the actual insurance coverage and benefits. We can not guarantee ANY insurance payment due to the complexities of insurance contracts. All balances unpaid by insurance remain the client's responsibility.

**Appointment Scheduling, cancellation and no-show policies**

All appointments are scheduled by your assigned counselor. Every attempt will be made to schedule times that are convenient for you. If you are unable to keep your scheduled appointment, Christian Counseling Associates require a 24-hour advance cancellation notice.

**Without this notice, you will be charged a \$40 cancellation fee.** Interest can be attached to any extended unpaid balance.

**Clinical emergency and after-hours procedures**

Normal office hours are Monday through Saturday by appointment from 9 am to 7 pm. During this time, your assigned counselor is available to return your call. If you are experiencing a clinical emergency after regular business hours, please call 911 or go to your nearest hospital emergency waiting room.

**Termination of treatment**

You may terminate treatment for any reason. Upon your request, CCA will be happy to provide you with a referral to another qualified provider. If you sign a release of information at that time, CCA will gladly forward a copy of your records to your new provider. If you cancel more than three appointments in any two-month period, or do not appear for two or more appointments within three months without giving 24-hour notice, your care may be transferred to another provider, at CCA’s discretion.

**Client Agreement**

I agree that I have read and understand the policies stated above. I acknowledge that I may request a copy of this Client Agreement for Counseling Services form. I understand that a copy of this Agreement will be kept on file.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_



## CONSENT TO TREATMENT

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I have received a copy of my *Client Agreement for Counseling Services* as a client of Christian Counseling Associates of Western Pennsylvania (CCA). This includes information about the nature of counseling, as well as guidelines for an effective counseling process. I also have received a copy of CCA's *Notice of Privacy Practices*, which explains the ways in which confidential medical information may be used, disclosed, or accessed according to federal law and as contained in the *Health Information Portability and Accountability Act (HIPAA)*, effective April 14, 2003. I understand that it is my right to read these documents before signing this form, and that I am entitled to a copy of this and any other consent form that I sign.

I am aware that communication with my counselor is noted and kept in a confidential file. I understand that, unless I authorize and sign a release of information form, it is the provider's policy to safeguard any information it gathers about me, as well as the medical records it compiles, from anyone who is not directly involved in my treatment. I further understand that, in cases of couple or family counseling, all participants over the age of 18 must authorize this release.

I understand that HIPAA mandates some exceptions to absolute confidentiality. These include:

1. The counselor's right to use or disclose any medical information that may be required for purposes of carrying out treatment and related healthcare operations, and for obtaining payment for services.
2. The requirement that the counselor shares with the proper authorities: reports or evidence of child abuse; reports or actions of suicidal or homicidal intent; and situations of life-threatening medical emergency. In such instances, my consent is not required.

I understand that I may request additional restrictions, beyond those stipulated in HIPAA, on the use and disclosure of my medical information, and that, while not required to agree to such requests, the counselor will cooperate as far as possible. Where there is agreement, however, the restrictions will be binding on the counselor.

I understand that, although my file is the property of the counselor's, I have a right to review and discuss the information in it, or to obtain a copy or summary of it at a reasonable charge. I am aware that my counseling relationship with the CCA counselor will not deprive me of any civil rights, nor will I be discriminated against by the CCA counselor.

I have been informed of my counseling fee and of the payment schedule.

By signing below, I consent to treatment and acknowledge that CCA and its physicians, employees, or agents may use or disclose my medical information as deemed appropriate (and according to state and federal law) to carry out treatment and related health-care operations, and to obtain payment for services.

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Signature of Client or Legal Representative

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Date

*If you are a legal representative, please check the basis for your authority:*

- Custodial Parent
- Guardianship Order (attach copy)
- Power of Attorney (attach copy)

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Counselor Signature

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Date



### **Additional Recommended Options for your Counseling Program at CCA**

*Please check boxes below to order or to receive further information*

#### **Cognitive Testing - Price \$ 25.00**

Cognitive testing by Cambridge Brain Sciences is available at CCA and is a recommended tool for measuring your overall brain health. When purchased this tool will be available throughout your counseling experience. Cognitive Testing allows you to measure and track key aspects of your brain health that are core to your quality of life. It also allows you to track your improvement in brain health areas associated with Depression, Attention-Deficit Hyperactivity Disorder (ADHD), Post-Traumatic Stress Disorder (PTSD), Memory issues, and more.

This assessment tool is emailed to you and can be completed at home. Complete the testing at your convenience and the results will be provided to you at your next counseling session. Re-test by request or at the direction of your CCA Counselor to gauge improvement (at no extra cost) during your counseling experience.

#### **Myers Briggs Personality Type Indicator (MBTI) - Price \$60**

The Myers Briggs Personality Type Indicator is a psychological assessment designed to accelerate self-understanding and help develop insight into how you differ from people of other personality types. Taking this assessment and receiving feedback will help you identify your unique gifts. The information will enhance your understanding of yourself, your motivations, your natural strengths, and your potential areas for growth. It will also enhance your ability to manage challenging relationships.

This assessment tool is emailed to you and can be completed at home. Complete the testing at your convenience and the results will be provided to you at your next counseling session.

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## **Alpha-Stim Treatment for Anxiety, Depression and Insomnia - Price \$75/month**

Alpha-Stim is a medical device used worldwide by healthcare professionals for treatment of anxiety, depression and insomnia. Doctor and patient surveys reveal it has helped 90% of the patients who tried it, and it is supported by over 95 completed independent research studies and published reports. Alpha-Stim treats patients utilizing a small electrical current through a handheld device that is typically used for 20 minutes per day. Clients struggling with depression, anxiety and insomnia have been shown to receive significant benefit through the reduction of symptoms when using Alpha-Stim.

Alpha-Stim provides therapeutic, lasting results without the risks of dangerous side effects, tolerance and addiction associated with many psychiatric medications. Alpha-Stim units are made available at CCA for at-home use for a monthly fee or the unit may also be purchased.

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I would like to submit a credit card to order the above items with CCA

I am interested in the checked items above but will need more information. Please provide additional information about these items during my counseling session.

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I acknowledge that I received the above information regarding recommended options to support my counseling program at CCA. I understand that the above items are optional and are not reimbursable by my insurance plan.

Client Signature: \_\_\_\_\_

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101 Pembroke Court, Greensburg, PA 15601



724-396-1510



724-972-4627



CCAWPA.com



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CCAWPA