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:**

CHRISTIAN COUNSELING ASSOCIATES
OF WESTERN PENNSYLVANIA
Richard Hoffman Ph.D., Clinical Director

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_____

CHRISTIAN COUNSELING ASSOCIATES
OF WESTERN PENNSYLVANIA
Richard Hoffman Ph.D., Clinical Director

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.

_____ _____

Signature of Client or Legal Representative 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)

_____ _____

Counselor Signature Date