

PAYMENT POLICY AND BILLING PROCEDURES

Unless 100% coverage has been verified with no copay, no co-insurance, and no deductible, you are responsible for the copay/co-insurance per visit and/or deductible not covered by your insurance company. This payment is required at the time of each visit. Your verified copay/co-insurance is _____ per visit. Your deductible is \$_____per plan year. There is a \$25.00 charge for all returned check.

Payment for all supplies are due at time of visit. Worker’s Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will be your responsibility.

CONSENT TO TREATMENT

I understand I have been referred by my physician or myself for treatment and care, to Comprehensive Therapy Centers. I understand that I have the right to ask and have any questions answered before receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Comprehensive Therapy Centers provide treatment and care a prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of Comprehensive Therapy Centers. I hereby authorize Comprehensive Therapy Centers to furnish my insurance company(s), attorney, or legal representative all information, which said parties might request concerning my present illness or injury. I hereby assign Comprehensive Therapy Centers all money to which I am entitled for medical expenses related to the service reported herein, but not exceed my indebtedness to Comprehensive Therapy Centers. It is understood that any money received from; above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I am financially responsible for these charges in addition to any percentage based collection fees, costs per our prevailing collection company contract, attorney fees, court costs, service fees and associated miscellaneous fees and costs associated with collection on this account. Comprehensive Therapy Centers or any assignee may contact me or responsible parties at any telephone number provided, or subsequently discovered, regarding the services or billing.

ATTENDANCE POLICY

If you unable to attend or you will be late for your appointment, please notify the center in advance. We urge you to call 24 hours prior to your scheduled appointment if you need to cancel your appointment to avoid a **\$50 fee** (fee applies to counseling patients only). Please be aware that your insurance will not pay for your late cancel or no show fees.

If you are covered by workers compensation insurance and you fail to keep the appointments that are recommended by your therapist and physician, the appropriate parties need to be notified of your absence.

PHONE CONTACT

Occasionally we may need to contact you by phone to confirm or reschedule an appointment

- YES NO May we call you at home or cell?
- YES NO May we leave a message if you are unavailable
- YES NO May we call you at work?

I authorize CTC to disclose my health information that is directly related to my health treatment to these individual(s). By listing these individuals below and signing below, you authorize CTC to release personal health information to them: If you do not wish to add anyone to your disclosure put "none" and sign and date.

Name	Relationship

I acknowledge that I have received a copy of Comprehensive Therapy Centers Notice of Privacy Practices. By signing below I consent to CTC use and disclosure or protected health information about me for treatment, payment and healthcare operations. I certify by my signature that I have read and agree to this information.

Patient Name (Print)

Patient Signature Date

Parent or Guardian Name (Print)

Parent or Guardian Signature Date

INDIVIDUAL/FAMILY INTAKE FORM

Patient Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____

If Minor Child:

Parent/Guardian Name: _____

Do you presently have custody of child? Yes No

Visitation schedule: _____

In home are:

Adult: _____ Age: _____

Children: _____ Age: _____

EMERGENCY CONTACT PERSON:

Name: _____ Relationship: _____ Phone: _____

Past/Present health problems of client: _____

Current Medications: _____

Prescribing Physician: _____

Past Counseling experiences: _____

General goals for counseling: _____

1. **In the past three years has your child:**

- | | | | |
|--|---------|----------|-----------|
| a. Stolen more than once? | No_____ | Yes_____ | Ages_____ |
| b. Run away from home more than once? | No_____ | Yes_____ | Ages_____ |
| c. Lied often? | No_____ | Yes_____ | Ages_____ |
| d. Set fires? | No_____ | Yes_____ | Ages_____ |
| e. Been truant from school? | No_____ | Yes_____ | Ages_____ |
| f. Deliberately destroyed other's property? | No_____ | Yes_____ | Ages_____ |
| g. Broken into someone's house, building or car? | No_____ | Yes_____ | Ages_____ |
| h. Been physically cruel to animals? | No_____ | Yes_____ | Ages_____ |
| i. Used a weapon in a fight? | No_____ | Yes_____ | Ages_____ |
| j. Had more than one physical fight with peers? | No_____ | Yes_____ | Ages_____ |
| k. Had Juvenile Court involvement? | No_____ | Yes_____ | Ages_____ |

If yes, when and what were the charges?

Names of probation officer / court worker:

2. **Over the past three years has your child?**

- | | | | |
|---|---------|----------|-----------|
| a. Repeatedly lost his/her temper? | No_____ | Yes_____ | Ages_____ |
| b. Often argued with adults? | No_____ | Yes_____ | Ages_____ |
| c. Often defied or refused adult requests or rules? | No_____ | Yes_____ | Ages_____ |
| d. Deliberately annoyed other people? | No_____ | Yes_____ | Ages_____ |
| e. Blamed others for his/her mistakes? | No_____ | Yes_____ | Ages_____ |
| f. Been easily annoyed by others? | No_____ | Yes_____ | Ages_____ |
| g. Been angry and resentful? | No_____ | Yes_____ | Ages_____ |
| h. Been spiteful or vindictive? | No_____ | Yes_____ | Ages_____ |
| i. Sworn a lot or used obscene language? | No_____ | Yes_____ | Ages_____ |

3. **Over the past year has your child had:**

- | | | | |
|--|---------|----------|-----------|
| a. Excessive or unrealistic worry about future events? | No_____ | Yes_____ | Ages_____ |
| b. Excessive concern over past behaviors? | No_____ | Yes_____ | Ages_____ |
| c. Excessive concern about his/her competence?
(athletic, academic, social) | No_____ | Yes_____ | Ages_____ |
| d. Complaints of headaches or stomachaches? | No_____ | Yes_____ | Ages_____ |
| e. A lot of self-consciousness? | No_____ | Yes_____ | Ages_____ |
| f. Tension and difficulty relaxing? | No_____ | Yes_____ | Ages_____ |
| g. Excessive need for reassurance from others? | No_____ | Yes_____ | Ages_____ |

4. **Over the past year has your child:**

- | | | | |
|--|---------|----------|-----------|
| a. Had excessive fear of weight gain? | No_____ | Yes_____ | Ages_____ |
| b. Had excessive weight loss? | No_____ | Yes_____ | Ages_____ |
| c. Felt fat when he/she isn't? | No_____ | Yes_____ | Ages_____ |
| d. Dieted excessively? | No_____ | Yes_____ | Ages_____ |
| e. Used laxatives, diuretics or speed? | No_____ | Yes_____ | Ages_____ |
| f. Self-vomited after meals? | No_____ | Yes_____ | Ages_____ |

5. **Recently has your son or daughter used:**

- | | | | | |
|---------------------------------------|---------|----------|-------------------|-----------------|
| a. Alcohol? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| b. Amphetamines? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| c. Marijuana? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| d. Cocaine? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| e. Sedatives, hypnotics, anxiolytics? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| f. Hallucinogens? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| g. Inhalants? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |
| h. Opioids? | No_____ | Yes_____ | Occasionally_____ | Frequently_____ |

6. **Over the past year has your son or daughter:**
- | | | | | |
|---|---------|----------|------------|------------|
| a. Had a significant depressed (sad) mood? | No_____ | Yes_____ | Minor_____ | Major_____ |
| b. Been very irritable? | No_____ | Yes_____ | Minor_____ | Major_____ |
| c. Been less interested in most activities? | No_____ | Yes_____ | Minor_____ | Major_____ |
| d. Gotten less pleasure than usual from activities he/she enjoys? | No_____ | Yes_____ | Minor_____ | Major_____ |
| e. Lost a good deal of weight? | No_____ | Yes_____ | Minor_____ | Major_____ |
| f. Complained of or has a lack of appetite? | No_____ | Yes_____ | Minor_____ | Major_____ |
| g. Been unusually tired and listless? | No_____ | Yes_____ | Minor_____ | Major_____ |
| h. Had difficulty falling asleep at night? | No_____ | Yes_____ | Minor_____ | Major_____ |
| i. Had difficulty remaining asleep at night and waking earlier than normal? | No_____ | Yes_____ | Minor_____ | Major_____ |
| j. Felt guilty or worthless (low self-worth)? | No_____ | Yes_____ | Minor_____ | Major_____ |
| k. Had difficulty concentrating in school or at home? | No_____ | Yes_____ | Minor_____ | Major_____ |
| l. Mentioned suicide or felt like dying? | No_____ | Yes_____ | Minor_____ | Major_____ |
| m. Attempted suicide? | No_____ | Yes_____ | Minor_____ | Major_____ |
| n. Been more withdrawn than usual? | No_____ | Yes_____ | Minor_____ | Major_____ |

7. **Over the past year has your son or daughter acted:**

- | | | |
|----------------------------------|---------|----------|
| a. Fidgety, squirmy? | No_____ | Yes_____ |
| b. Restless? | No_____ | Yes_____ |
| c. Impulsive? | No_____ | Yes_____ |
| d. Poorly attentive? | No_____ | Yes_____ |
| e. Easily distracted? | No_____ | Yes_____ |
| f. Unable to remain seated? | No_____ | Yes_____ |
| g. Talked excessively? | No_____ | Yes_____ |
| h. Very difficult to discipline? | No_____ | Yes_____ |

8. **Were there serious marital/couple/family problems during this period?** No_____ Yes_____

9. **How were the problems manifested in the home? (yelling, physical violence) and how did the child react to these problems?** _____

10. **To your knowledge, has your child been sexually victimized (fondled, sexually abused, raped)?** No____ Yes____
 If yes, at what age (s)? _____ and by whom? _____

11. **Was your child ever physically or emotionally abused?** No_____ Yes_____
 If yes, at what age (s)? _____ and by whom? _____

12. **Has your child recently (while not on drugs):**
- | | | |
|--|---------|----------|
| a. Heard voices talking to him/her (hallucinations)? | No_____ | Yes_____ |
| b. Had bizarre or very unusual thoughts? | No_____ | Yes_____ |
| c. Exhibited odd behaviors? | No_____ | Yes_____ |

13. **Please describe, as best you can, your child's personality (emotional makeup). Be as descriptive as you can:**

14. **Please describe what forms of discipline you have tried and how successful or unsuccessful your methods have been. Do both parents/partners discipline the same way? Are you consistent in your handing out of consequences? What do you use as a consequence?**

