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 Counseling 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 Counseling 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 Counseling Centers. I hereby authorize Comprehensive Counseling 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 Counseling Centers all money to which I am entitled for medical expenses related to the service reported herein, but not exceed my indebtedness to Comprehensive Counseling 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 Counseling 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 CCC 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 CCC 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 Counseling Centers Notice of Privacy Practices. By signing below, I consent to CCC 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: _____

THE BURNS ANXIETY INVENTORY®

Instructions: The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

Symptom List:	NOT AT ALL	SOMEWHAT	MODERATELY	A LOT
CATEGORY I: ANXIOUS FEELING				
1. Anxiety, nervousness, worry, or fear.				
2. Feeling that things around you are strange, unreal or foggy.				
3. Feeling detached from all or parts of your body.				
4. Sudden unexpected panic spells.				
5. Apprehension or a sense of impending doom.				
6. Feeling tense, stressed, "uptight", or on edge.				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating.				
8. Racing thoughts or having your mind jump from one thing to the next.				
9. Frightening fantasies or daydreams.				
10. Feeling that you're on the verge of losing control.				
11. Fears of cracking up or going crazy.				
12. Fears of fainting or passing out.				
13. Fears of physical illness or heart attacks or dying.				
14. Concerns about looking foolish or inadequate in front of others.				
15. Fears of being alone, isolated, or abandoned.				
16. Fears of criticism or disapproval.				
17. Fears that something terrible is about to happen.				
CATEGORY III: PHYSICAL SYMPTOMS				
18. Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19. Pain, pressure, or tightness in the chest.				
20. Tingling or numbness in the toes or fingers.				
21. Butterflies or discomfort in the stomach.				
22. Constipation or diarrhea.				
23. Restlessness or jumpiness				
24. Tight, tense muscles.				
25. Sweating not brought on by heat.				
26. A lump in the throat.				
27. Trembling or shaking.				
28. Rubbery or "jelly" legs.				
29. Feeling dizzy, lightheaded, or off balance.				
30. Choking or smothering sensations or difficulty breathing.				
31. Headaches or pains in the neck or back.				
32. Hot flashes or cold chills.				
33. Feeling tired, weak, or easily exhausted.				

----------THE BURNS DEPRESSION CHECKLIST®----------

	NOT AT ALL	SOMEWHAT	MODERATELY	A LOT
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a failure?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself for everything?				
6. Indecisiveness: Do you have trouble making up your mind about things?				
7. Irritability and frustration: Have you been feeling resentful and angry a good deal of the time?				
8. Loss of interest on life: Have you lost interest in you career, your hobbies, your family, or your friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost you appetite? Or do you overeat or binge compulsively?				
12. Sleep changes: Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
13. Loss of libido: Have you lost interest in sex?				
14. Hypochondriasis: Do you worry a great deal about your health?				
15. Suicidal impulses: Do you have thoughts that life is not worth living or think that you might be better off dead?				

Name:

Date: