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: _____

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 easley 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 then 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?**
_____
_____
_____