Reclaimed Counseling Center

Client Data Form

Client Information

Name: Last:_____ First:_____Sex:_____
DOB:_____Marital Status:_____

Street
Address:_____City:_____State:_____
__ Zip:_____

Home Phone:_____Cell:
_____Business:_____

OK to leave message?: (H) (C) (B) Email:_____

Emergency Contact:
This is in case of a medical or psychiatric emergency. This emergency contact person should be someone with whom you have frequent contact and would be most aware of any physical, psychiatric, and emotional issues that you have been experiencing. If this contact is not available in an emergency or if you cannot identify a contact person, 911 may be called to ensure personal safety.

Name: _____ Relationship: _____
PH:_____

Physician Name:_____ PH:_____ Last appointment date:_____

Insurance Information:

Primary Insurance:
_____Group:_____ID#:_____
_____

Phone for MH Benefits: _____
Employer:_____
Is patient policy holder: (Y) (N)

Policy holder name:_____ Relation to client:_____
DOB:_____

Secondary Insurance:_____ Group:_____
ID#:_____

Benefit Check (office use only)

In-Network: Effective date:_____ Preexisting:_____ Deductible:_____ Met for year:_____

Yr'ly session max:_____ $ max visit:_____ Life max:_____ **Copay:**_____
CoIns:_____

Serious/Non-S: % Ins coverage _____/_____ % clt coverage _____/_____ Family TX covered: (Y) (N)

Pre-cert: (Y) (N) Pre-Cert PH:_____ Auth #:_____
Start/End:_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION OF COMMUNICATION & GUARANTEE OF PAYMENT: I

authorize and instruct my insurance company, if any, to pay any and all relevant benefits directly to the therapist. I understand, and guarantee, that I am responsible for all charges not covered by my group or individual insurance plans. I authorize therapist to communicate with my insurance company and any 3rd party billing service regarding my benefits via phone, fax, mail, and electronic fax executed by a 3rd party when applicable.

_____ / _____ / _____

Signature Date Witness

Informed Consent

Welcome. Thank you for choosing Reclaimed Counseling Center. These guidelines have been written to inform you, the client, about the basic terms, conditions and professional practices that promote a successful therapeutic experience. Please read this information carefully and acknowledge your understanding by signing below.

Appointments. At the beginning of treatment, the client will have a minimum of one session per week lasting 45-50 minutes in duration. For best results, it is important to maintain consistent attendance on a regular basis. All appointments need to be scheduled in advance.

Appointments canceled with less than 24 hours in advance will be charged the full fee.

This charge will be the client's responsibility since insurance companies do not pay for "no shows." The client will be charged what would normally be reimbursed by the insurance company or the agreed upon out-of-pocket rate. In cases of or special circumstances where a 24 notice is not possible, the fee may be waived.

Payment for Services. Co-payment or payment for services is due at the time of the appointment. Reclaimed Counseling Center accepts checks, cash and credit card. A credit card may be kept on file for convenience if agreed upon by the client and therapist.

Confidentiality. All information disclosed in therapy sessions, including case notes and records, will be kept strictly confidential. No information will be disclosed without the client's (or legally authorized representative) expressed written consent unless an applicable legal exemption exists. ***However, the therapist is required by law to report any disclosed or suspected child, elder, or dependent adult abuse and any situation where the client threatens violence to an identifiable victim or self.***

Contacting Information. For non-urgent matters in-between appointments, you may contact the Reclaimed Counseling Center directly at the number provided. Please allow a 24 hour response window. Reclaimed Counseling Center does ***NOT*** provide 24 hour crisis services. In case of crisis, call 911 or go to your nearest emergency room.

I agree to pay for all services provided up until the time the therapy relationship is terminated. I have read and understand all of the terms and conditions stated above regarding therapy. All my questions have been answered fully. I understand and agree to the terms and conditions of this agreement.

_____	_____	_____
Date	Signature of Client	Printed Name
_____	_____	_____
Date	Signature of Client	Printed Name

Reclaimed Counseling Center

Notice of Privacy Practices – Short Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

Commitment to your privacy

Reclaimed Counseling Center is dedicated to maintaining the privacy of your personal health information. We are also required to do so by law. Although these laws are complicated, you must be provided with important information. This document is a shorter version of the full, legally required NPP, which is available to you upon request. Also, since these documents can't cover all possible situations, please talk with me directly about any questions or concerns.

I will use the information about your health, which I receive from you or from others, mainly to provide you with treatment, to arrange payment for our services, or for other business activities that are called health care operations. After you have read this NPP, you will be asked to sign a consent to treat form. If you do not consent and sign this form, I will be unable to provide you with treatment.

If I need to send, share or release your information for any other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Of course, I will keep your health information private; however there are times when the law requires me to use or share it such as:

1. when there is a serious threat to your health and safety, to the health and safety of another individual, or to the public. IN such an even, I will only share information with a person or organization that is able to help prevent or reduce the threat.
2. in some lawsuits, and legal or court proceedings
3. in a law enforcement official requires me to do so
4. for Workers Compensation and similar benefit programs

There are other situations that don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or particular place. For example, you can ask to be called at home, and not at work, in order to schedule or cancel an appointment.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or in the payment for your care such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement unless it is against the law, in case of emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information that I have about you, such as your medical and billing records. You can get a copy of these records for a minimal administrative fee.
4. If you believe the information in your records is incomplete or incorrect, you can ask us to make some kinds of changes (called amending) to your health information. You must make this request in writing. You must also explain the reasons you want to make the changes.
5. You have the right to a copy of the NPP. If I make changes, I will notify you and post them in the waiting room.
6. You have the right to file a complaint if you believe that your privacy rights have been violated.

If you have any concerns regarding this notice or about other health information policies, please contact Bethany Hart at (317)537.7906

Reclaimed Counseling Center
Bethany Hart, MA, LMHC

Privacy Policy Signature Page

I, _____, acknowledge being offered and receiving a copy of the Notice of Privacy Practices of Reclaimed Counseling Center in accordance with the Health Insurance Portability and Accountability Act.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

_____ _____
Witness Date

Reclaimed Counseling Center

Credit Card Authorization Form

Charges on your credit card will appear as Reclaimed Counseling on your credit card statement. Receipts for charges will be given to you upon your request. I will only keep your credit card information on file for the course of treatment. Upon termination, the bottom part of this document containing your credit card information will be shredded.

I, _____ hereby authorize Bethany Hart, MA,LMHC to charge my credit/debit card for charges related to services rendered at Reclaimed Counseling Center. I understand that I am responsible for payment of services rendered. Charges may include co-pays, fees for service, and may include no-show/late cancel fees as specified in my signed inform consent form. My signature on this form authorizes charges on my credit card.

_____ _____

Signature: Date:

_____ _____

Witness: Date:

Credit Card Information Listed Below: _____

Card Type:_____ Name on Card:_____

Card #:_____ Exp Date: _____ Security Code: _____

Street Address Associated with Card:

_____

Zip Code: _____