Therapist: _____
DX: _____
Date: _____

Comprehensive Counseling Services

PATIENT INFORMATION SHEET

Patient Name: _____ Home Phone :(___) _____
Cell Phone: (___) _____
Patient Address: _____
Street City State Zip
Patient Social Security #: _____ Patient Date of Birth: _____
Patient's Age: _____ Referral Source: _____
Patient's Marital Status: _____ Patient's Sex: _____
Responsible Party: _____
Relationship to Patient: ☐Self ☐Spouse/Partner ☐Parent ☐Foster Parent
☐ Other (specify) _____
Email address: _____
Patient Employer or School: _____ Position/Grade: _____
Employer Address: _____ Work Phone: _____
Spouse/Partner/Guardian Name: _____ SS #: _____
Spouse/Partner/Guardian Employer: _____ Position: _____
Employer Address: _____ Work Phone: _____
Notify in Case of Emergency: _____ Phone: _____

FOR MINOR PATIENTS, PLEASE COMPLETE**

Father's Name: _____ SS#: _____
Father's Address: _____ Home Phone: _____
Father's Employer: _____Work Phone: _____
Mother's Name: _____ SS #: _____
Mother's Address: _____ Home Phone: _____
Mother's Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____
Insured's Name: _____ Group #: _____
Secondary Insurance: _____ Policy #: _____
Insured's Name: _____ Group #: _____

CALLS REGARDING APPOINTMENTS

Upon occasion, Comprehensive Counseling staff may need to contact you regarding an upcoming appointment. Please read, answer and sign below:

~ Permission to call your home phone number listed? _____
~ Permission to leave a message on home phone? _____
~ Permission to call your cell number listed? _____
~ Permission to leave a message on cell phone? _____
~Permission to call your work phone number listed? _____
~Permission to leave a message at work? _____
~Permission to email you? _____

Preferred phone to call you on: _____

Patient signature (if over 18): _____ Date: _____

If a minor, Parent/Legal Guardian signature: _____ Date: _____

CANCELLATION POLICY

Comprehensive Counseling Services requires appointments be cancelled 24 hours in advance. If your appointment is not cancelled 24 hours in advance, you will be charged a Late Cancellation Fee of $25.00. If you fail to show for your scheduled appointment, you will be charged a $50.00 No Show Fee for that appointment. This amount is not billed to insurance, and the full fee is due at your next scheduled appointment.

*** In the event of a family emergency or sudden illness, please call before the appointment to notify the counselor of such circumstances.***

Patient signature (if over 18): _____ Date: _____

If a minor, Parent/Legal Guardian signature: _____ Date: _____

COMPREHENSIVE COUNSELING SERVICES
FINANCIAL POLICY

***All patients, parents, guardians and grantors are required by Comprehensive Counseling Services, to read the following Financial Policy and to sign it stating you agree to the terms and conditions of this policy:**

1. Proof of Insurance: You are required to bring your insurance card(s) with you to every appointment. It is your responsibility to inform the office if a visit should be billed to someone other than your regular insurance.
2. Payment is due AT TIME OF SERVICE; we accept cash, personal checks and all credit cards as form of payment for services. All deductibles, co-pays and non-covered services are due at time of service unless payment arrangement have been made in advance with the Office Manager.
3. Please be aware that it is our obligation under many managed care contracts to report patients who repeatedly refuse to pay their cop-pays and deductibles at time of service or who repeatedly "No Show" for appointments.
4. You agree as a patient of Comprehensive Counseling Services, if you change, terminate or receive another insurance coverage, you will notify our office immediately.
5. If an overpayment is made on your account, a refund will only be issued if there are no outstanding debts on other accounts containing the same guarantor of financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes.
   It is your responsibility to inform us of any change in your address, phone number, insurance or employment.
6. ALL BALANCES ARE DUE IN FULL within 30 days of the billing date. If you cannot pay the balance in full within 30 days, please contact our office to see if you qualify for any special arrangement options.
7. Failure to meet your financial obligations may result in placing your account with our collections attorney. You will then be responsible for attorney fees of 25% of the outstanding principal balance at the time the account is turned over, court costs, interest and other expenses related to collecting your account will be added to your outstanding balance. If your account with Comprehensive Counseling is turned over to our attorney, you will be terminated as a patient from our facility.
8. You agree that if your account balance goes past 60 days, interest will be added to the balance at the rate of 1.5% per month.

Patient Signature (if 18 or over): _____ Date: _____

Guardian/Grantor Signature: _____ Date: _____

Office Staff Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process services rendered. I also authorize payment of medical benefits directly to Comprehensive Counseling Services for services described on the insurance claim form and otherwise payable to me. I understand I am financially responsible to this facility for all charges not covered by any third party payer. I also agree that if services performed are non-covered benefits or not authorized by a referral yet I consent to such services, I am financially responsible for non-payable charges.

If a referral is required by my insurance company to pay for services provided, it is my responsibility to obtain this document. It is also my responsibility to provide my insurance company with documentation they request from me. I authorize the use f this signature on all of my insurance claim submissions.

_____ _____

Responsible Party Signature Date

CONSENT TO TREAT

By signing below I acknowledge that I am consenting to treatment for myself or for my child, at this facility.

_____ _____

Patient/Parent/ Legal Guardian Signature Date

PATIENT'S RIGHTS AND RESPONSIBILITIES

Statement of Patient Rights

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age disability or source of payment.
- Patients have the right to have their treatment and other information kept private.
- Only in life-threatening situations or if required by law, can records be released without a signed and consent from patients.
- Patients have the right to information from staff/providers in a language they can understand.
- Patients have the right to an easy to understand explanation of their condition and treatment.
- Patients have the right to know all about their treatment choices regardless of cost coverage.
- Patients have the right to get information about services offered by their providers and patient role in the treatment process.
- Patients have the right to request professional information about their provider.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide suggestions on office policies and procedures.
- Patients have the right to complain and to know about their complaint, grievance and appeals process.
- Patients have the right to know about State and Federal laws governing their rights and responsibilities.
- Patients have the right to participate in the formation of their plan of care.

Statement of Patient Responsibilities

- Patients are responsible for providing their medical provider with information needed to deliver quality care.
- Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
- Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers including any changes in medications.
- Patients are responsible for reviewing their care and treatment plans continuously and reporting effectiveness or ineffectiveness of the care plan to their provider.
- Patients are responsible for treating those giving them care with dignity and respect.
- Patients should not be involved in any conscious behavior that could harm the lives of their providers, office staff or other patients.
- Patients are responsible for keeping their appointments, arriving on time and notifying the office of any cancellations at least 24 hours prior to the appointment.
- Patients are responsible for addressing questions about their care to their provider and ensure understanding of their role in the treatment process.
- Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverage.

I understand my rights and responsibilities as stated on this sheet.

_____

Patient/Parent/Legal Guardian Signature

_____

Date Signed

Revised: 5/18/10

COMPRHENSIVE COUNSELING SERVICES, INC.
NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements we may give out health information without your authorization for public health purposes, of auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each counseling office. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information Belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use of disclose health information except to the extent that action has already been taken.

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written conmplaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by low to protect the privacy of ;your information, provide this notice about our information practices and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact Sally Chamberlain at 1115 First St. SW, Roanoke, VA 24016.
Phone #: 540-343-0004 or email: **sallyc@ccs.roacoxmail.com**

Written Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to the restrictions I request.

_____ _____

Signature or Patient/Parent/ Legal Guardian/Representative Office Staff

Date Signed: _____ Date:_____

Revised: 5/18/10