Therapist: _____

DX: _____

Date: _____

COMPREHENSIVE COUNSELING SERVICES

For Children, Adolescents, Families, Adults and Couples

1115 First Street S.W.
Roanoke, VA 24016

Phone (540) 343-0004
Fax (540) 343-1576

Patient Information Form

Patient Name: _____
Preferred Name:_____
Date of Birth: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____
Patient Address: _____
Street City State Zip
Patient Social Security #:_____

Patient's Sex: Male _____ Female_____ Trans Male (FTM)_____ Trans Female (MTF)_____ Non Binary _____

Preferred Pronouns: She/Her/Hers _____ He/Him/ His _____ They/Them/Their _____
Status: Straight _____ Gay/Lesbian _____ BiSexual _____ Other _____

Responsible Party: _____
Relationship to Patient: □ Self □ Spouse/Partner □ Parent
□ Foster Parent □ Other: _____
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 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 $35.00. If you fail to show for your scheduled appointment, you will be charged a $65.00

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: _____

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 of this signature on all my insurance claim submissions.

_____ _____

Responsible Party Signature Date

CONSENT TO TREATMENT :

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

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 arrangements 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 co-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 not 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 out 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: _____

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 release 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 medial 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 question 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 of insurance coverage.

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

_____ _____

Patient/Parent/Legal Guardian Signature Date Signed

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Roanoke, VA 24016 *Fax (540) 343-1576*

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I _____,
acknowledge that I received a copy of the Notice of Privacy Practices.

_____ _____
Printed Name of Client Date

_____ _____
Signature of Client or Guardian Date

_____ _____
Signature of Therapist Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement