

Name of Child		DOB/	_/
Address where child resides		STATE	ZIP
LIST NAMES AND AGES OF SIBLINGS			
HAS CHILD EVER BEEN IN COUNSELING BEFORE? YES	NO WHEN?		
REASON	NDECC IN CO		
WHAT ISSUES DO YOU WISH YOUR CHILD TO DISCUSS AND ADD			
SCHOOL CHILD ATTENDS	GRADE		
CHILD'S PHYSICIAN			
CURRENT MEDICATIONS			
PARENT/ LEGAL GUARDIAN INFORMATION:			
NAME OF FATHER			
AddressCity			
PHONE #			
EMPLOYERP	PHONE#		
NAME OF MOTHER			
AddressCity			
PHONE #			
EMPLOYERPHONE#			
IS THERE A CUSTODY ORDER IN EXISTENCE? YES NO IF YES, WHO IS THE PRIMARY CUSTODIAN? ARRANGEMENTS?			
HAVE YOU EVER BEEN INVESTIGATED BY CHILD PROTECTIVE SE IF YES, PLEASE SHARE DETAILS:	RVICES OR DEPARTMENT C	OF SOCIAL SER	VICES?
LOCAL PREFERENCE OR RELIGIOUS PREFERENCE			
HOW DID YOU HEAR ABOUT OUR OFFICE?			
Policy Holder's Information:			
OLICY HOLDER'S NAME:			
OLICY HOLDER'S BIRTH DATE:			_
OLICY HOLDER'S EMPLOYER:			
			_
AUTHORIZATION#			
Person Responsible for Bill: (if different from			
IAME:			-
ADDRESS:			-
hone#:			
uthorization To Pay Benefits to Practitioner and to I	Release Information		
under the first term of the term of			

I hereby authorize CC at Concord to release any information acquired in the course of my treatment necessary to process insurance claims and to submit claims for and receive any benefits for which I (or the patient) may be eligible for services rendered by the practitioner, realizing I am responsible to pay non-covered services.

SIGNATURE (CLIENT OR PARENT IF MINOR)



Notice of Privacy Practice:

During this initial contact with you, we want to notify you of confidentiality and privacy issues. These practices are designed to protect your individual information and confidentiality. Although we have notified you with our privacy and confidentiality practices, we will give you a written copy of our **Notice of Privacy Practices** if you request. The written **Notice of Privacy Practices** outlines how we can use and disclose information along with the rights that you have regarding your information maintained by us.

ALSO, WE MUST OBTAIN WRITTEN ACKNOWLEDGEMENT THAT WE HAVE NOTIFIED YOU OF OUR PRIVACY PRACTICES WITH YOU. BY SIGNING THIS FORM, YOU ARE ONLY ACKNOWLEDGING THAT YOU HAVE BEEN INFORMED ABOUT OUR PRACTICES TO MAINTAIN PRIVACY AND CONFIDENTIALITY, AND HAVE READ THE **NOTICE OF PRIVACY PRACTICES.**

CHARGES AND PAYMENT INFORMATION:

The standard charge for a session (60 minutes) is \$135.00 for Initial Intake (\$125.00 for each visit afterward). In some situations where the standard fee would cause a severe financial hardship, clients may apply for reduced charges. Client assistance funds come from donations from individuals, churches, and businesses.

WE HAVE CONTRACTUAL ADJUSTMENTS WITH DIFFERENT SPONSORING ORGANIZATIONS WHICH ALLOW FOR ADJUSTED FEES. YOUR FEE WILL BE DISCUSSED WITH YOUR COUNSELOR. ANYTIME YOU HAVE FINANCIAL QUESTIONS, PLEASE DISCUSS THEM WITH YOUR COUNSELOR.

CANCELLATIONS AND MISSED APPOINTMENTS: CLIENTS ARE REQUESTED TO GIVE A MINIMUM 24-HOUR NOTICE TO CANCEL APPOINTMENTS.

APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS' NOTICE OR APPOINTMENTS MISSED ARE SUBJECT TO A CHARGE.

INSURANCE COVERAGE:

The center will assist you in filing for insurance benefits for covered services. If you intend to apply for insurance coverage, please present insurance policy information or a current insurance identification card at the reception area prior to your session. A photocopy of your insurance information will be made to assure that eligibility of coverage can be verified and that accurate claims can be filed. Full standard fee of \$125.00 (\$135 initial visit) must be charged when billing all insurance companies.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FILED ON MY BEHALF. I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS TO THE COUNSELING CENTER. I ACKNOWLEDGE THAT I AM FINANCIALLY AND LEGALLY RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED WHETHER MY HEALTH INSURANCE COVERS SERVICES RENDERED OR NOT.

I have read and understand the center's policy on Notice of Privacy Practices, charges, insurance billing, cancellations and missed appointments. I agree and accept financial responsibility for payment and services rendered. I have read and been informed about how my privacy confidentiality will be maintained by the Counseling Center @ Concord.

X		Date
	CLIENT/RESPONSIBLE PARTY	
UPDATED: 4/10/17		