FAMILY COUNSELING ASSOCIATES, INC.

INTAKE FORM

Thank you for coming for your first appointment to see one of our Providers at Family Counseling Associates, Inc. (FCA). In an effort to make your experience with us as pleasant as possible, we appreciate your taking the time to complete this form that will provide us all the information we need to handle your account, file your insurance (if requested), and guard your privileged information. You have also been given a copy of the Privacy Information Policy (Health Insurance Portability & Accountability Act [HIPAA] and The Health Information Technology for Economic and Clinical Health Act [HITECH]) for review and, if requested, we can provide a copy for your records. Your privacy at FCA is important to us and will always be guarded by all of our professionals and administrative staff.

USING YOUR HEALTH INSURANCE

The treatment you receive from FCA is based upon the professional judgment of our providers, and not on the coverage you receive from a health benefit plan. We do not believe it is in your best interests to compromise recommended treatment in order to accommodate any insurance program. It is for this reason FCA does not enter into contracts or agree to fee schedules with any insurance company. Most insurance companies do provide benefits for non-participating providers who are out-of-network, but in most cases the payments will be made to you (the member) rather than FCA (the provider). We will be happy to process your insurance against the services rendered by your FCA provider; however, we do ask for payment in full at the time of your first appointment. If, after determination of benefits, it is found that your policy will reimburse FCA, your provider may elect to only require you to pay your determined co-pay at the time of future sessions. Health insurance is a contract between you and your carrier. There categorically is no such thing as a "Usual and Customary" (UCR) fee for our services in any state or nation. These UCR fees are created internally by the insurance industry, not providers. When you receive treatment at FCA, you agree to be financially responsible for the entire fee from FCA, independent of the amount that may be paid by an insurance company. Insurance deductibles must also be satisfied before we can accept any co-payment. The adult (parent or legal guardian) accompanying a minor patient is responsible for payment of service fees at the time rendered.

MISSED AND CANCELLED APPOINTMENTS AND OVERDUE BALANCES

Missed appointments or cancellations with less than 24-hour notice prior to the scheduled appointment will result in a charged fee of $50. There is also a $25 fee for Returned Checks. Checks that are dishonored by your bank twice must be paid immediately with cash or a Credit Card to avoid further legal action. Any unpaid balances over sixty (60) days will be submitted to collections and additional finance charges and other costs, including reasonable attorney fees and court costs, may be applied. By accepting treatment from FCA you agree to these potential additional charges.

PAYMENT OPTIONS

Payment is due at the day/time of service. Payment for services can be made by Check, Cash, VISA, MasterCard or Discover Card. You are encouraged to allow FCA to keep your Credit Card information on file and give authorization for charges to be made on the account at the time of each session. This allows us to speed up your check-out time at the office and simplifies the accounting process. We will always make your transaction history available to you upon request and you will be given a Receipt at the time of your appointment.

HIPAA / HITECH ACKNOWLEDGEMENT

I have read and understand all of the information presented above in this form, and I have received my personal copy of this document.

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic and Clinical Health Act (HITECH). I understand this information will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain third party payment for my mental health care services, as applicable.
- Conduct normal mental health care operations such as quality assessment and improvement activities.

I have been informed of Family Counseling Associate's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected mental health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my mental health provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or mental health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Printed Name: _____

Signature: _____ Date: _____

(If Applicable) Signature of Parent/Guardian: _____ Date: _____

Family members also covered by this acknowledgement: _____

(Please list their names here)

PATIENT INFORMATION

The information in this section should pertain to the **individual who will be receiving services at FCA**. If that person is you, please provide this information about yourself. If the patient is your child, please provide information about your child. If you are seeking help for your marriage, we do need to identify only one of you as the "Patient" for purposes of account-keeping and filing of insurance (if applicable). Below, you will be able to give us information about the other spouse or parent (in the case of a child as the patient).

FIRST NAME _____ MIDDLE INITIAL _____ LAST _____

SUFFIX _____ NICKNAME _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ (EXT.____

CELLPHONE (_____) _____ E-MAIL _____

SEX (Circle One): Male Female MARITAL STATUS (Circle One): Single Married Divorced Widowed

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NO. _____-_____-_____

PLEASE INDICATE HOW OUR OFFICE SHOULD LEAVE MESSAGES FOR YOU (Check as many as preferred):

[ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] E-Mail

EMPLOYMENT (Check Appropriate): [ ] Employed Full-Time [ ] Employed Part-Time [ ] Not Employed

[ ] On Active Military Duty [ ] Retired [ ] Self-Employed

EMPLOYER: _____

STUDENT (Check if Appropriate): [ ] Full-Time [ ] Part-Time

ETHNICITY (Check Appropriate):

[ ] Alaska Native [ ] American Indian [ ] Asian [ ] Black or African American
[ ] Hispanic or Latino [ ] Native Hawaiian [ ] Other [ ] Other Pacific Islander
[ ] White or Caucasian

PRIMARY CARE PHYSICIAN: _____ PHONE: (_____) _____

WHO REFERRED YOU TO FCA? _____

AUTHORIZATION FOR TREATMENT AND/OR SERVICES:

This signed Consent authorized FCA Clinicians to provide Counseling Treatment, Therapy Services, Psychiatric Treatment, and/or Other Services as indicated by your provider and further affirms that all statements in this form are true and accurate, including custodial status of minor children.

_____ _____
Signature of Client/Patient *(Required)* Signature of Spouse if also Receiving Treatment *(Required)*

_____ _____
Date *(Required)* Date *(Required)*

IF YOU ARE THE RESPONSIBLE PARTY FOR THE ACCOUNT, IT IS NOT NECESSARY TO COMPLETE THIS PAGE. IF, HOWEVER, YOU WOULD LIKE US TO FILE YOUR INSURANCE OR INVOICE ANOTHER PARTY OR ORGANIZATION, YOU WILL NEED TO COMPLETE.

RESPONSIBLE PARTY INFORMATION

FIRST NAME _____ MIDDLE INITIAL _____ LAST _____

SUFFIX _____ RELATIONSHIP TO PATIENT: _____

CHURCH/ORGANIZATION/BUSINESS (If Appropriate:) _____

HOW MUCH DOES THE INDIVIDUAL/CHURCH/ORGANIZATION INTEND TO COVER? _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ (EXT.____

CELLPHONE (_____) _____ E-MAIL _____

EMPLOYER: _____

SEX (Circle One): Male Female MEMBER ID NUMBER: _____

HEALTH INSURANCE POLICY INFORMATION

INSURANCE COMPANY NAME: _____

INSURANCE TYPE (Check One): [ ] Group Policy [ ] Individual Policy

EFFECTIVE START DATE: _____/_____/_____ EFFECTIVE END DATE (If Applicable): _____/_____/_____

SEX (Circle One): Male Female MEMBER ID #: _____

GROUP NAME: _____ RELATIONSHIP TO PATIENT: [ ] Self [ ] Parent [ ] Other

GROUP/POLICY #: _____ PLAN CODE: _____

DATE OF BIRTH: _____/_____/_____

ADDRESS (If Different) _____

CITY _____ STATE _____ ZIP CODE _____

FAMILY COUNSELING Associates
Christ centered professional counseling

Please Do Not Write Below this Section

PSYCHIATRIST OR THERAPIST TO COMPLETE

[ ] S/P
[ ] F/F $_____
[ ] R/F _____
[ ] INSURANCE
[ ] COPY OF INSURANCE CARD
[ ] SCANNED IN EDOCUMENTS
[ ] MAP _____
[ ] MAP SIGNATURE(S)
[ ] EAP _____
[ ] EAP SIGNATURE(S)
[ ] OTHER _____
[ ] VISITS APPROVED

PLEASE COMPLETE THIS PAGE IF THE PATIENT IS A MINOR

LEGAL STATUS
(Check Appropriate)

[ ] Biological Parents are Married
[ ] Parents Divorced/Biological Mother has Sole Legal Custody
[ ] Parents Divorced/Biological Father has Sole Legal Custody
[ ] Parents Divorced/Biological Parents have Joint Legal Custody

RESIDENTIAL STATUS
(Check Appropriate)

[ ] Minor lives with both Biological Parents
[ ] Minor lives with Biological Mother
[ ] Minor lives with Biological Father

NOTE: by checking the appropriate box above, you are affirming, under the penalties for perjury, that the box indicated is true and accurate.

WHO IS BRINGING THE MINOR FOR TREATMENT SERVICES:

[ ] Both Parents
[ ] Father
[ ] Mother
[ ] Other _____

CONSENT FOR TREATMENT OF A MINOR MUST BE GIVEN BY AT LEAST ONE PARENT IF THE PARENTS ARE MARRIED.
IF THE BIOLOGICAL PARENTS ARE DIVORCED,
THE PARENT WITH SOLE LEGAL CUSTODY MUST GIVE CONSENT OR
BOTH PARENTS, IF THEY SHARE JOINT LEGAL CUSTODY. YOUR THERAPIST MAY REQUEST A COPY OF YOUR DISSOLUTION DECREE FOR VERIFICATION OF CUSTODIAL STATUS, IF NECESSARY.

MINOR'S FATHER

FIRST NAME _____ MIDDLE INITIAL _____ LAST _____

ADDRESS 1 _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ (EXT.____

CELLPHONE (_____) _____ E-MAIL _____

MARITAL STATUS (Check Appropriate): [ ] Married to Child's Mother [ ] Divorced and Single [ ] Divorced & Remarried

LEGAL CUSTODY STATUS: [ ] Sole Legal Custody [ ] Joint Legal Custody County where Divorced: _____

MINOR'S MOTHER

FIRST NAME _____ MIDDLE INITIAL _____ LAST _____

ADDRESS 1 _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ (EXT.____

CELLPHONE (_____) _____ E-MAIL _____

MARITAL STATUS (Check Appropriate): [ ] Married to Child's Father [ ] Divorced and Single [ ] Divorced & Remarried

LEGAL CUSTODY STATUS: [ ] Sole Legal Custody [ ] Joint Legal Custody County where Divorced: _____