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| **Client Information (Who will the therapist be seeing?)** |
| Last Name: First : Mi: |
| Address: City: State: ZIP: |
| ☐Home Phone : ☐ Cell Phone: ☐ Work Phone: |
| **Please check the box next to the contact number you would like us to use for verbal communications.** |
| Date of Birth : / / Male: Female : SS# / /  |
| Emergency Contact: Phone: Text ok? Yes or No  |
| Employer: Address: |
| Primary Physician : Referred by: |
| **Responsible Party (If Not Patient)** |
| Last Name: First : MI: |
| Address: City: State: Zip: |
| Home Phone : Cell Phone: Work Phone: |
| **Billing Information** |
| 1st Insurance Company: Phone : |
| Address: City: State: Zip: |
| \*Name of Subscriber (policy holder): Relationship: |
| ID# Group# |
| \*Subscribers Date of Birth / / Male Female  |
| **\*required to process insurance Claims** |
| 2nd Insurance Company: Phone:  |
| Address: City: State: Z ip: |
| \*Name of Subscriber (policy holder): Relationship: |
| ID# Group# |
| \*Subscribers Date of Birth: / / Male Female  |
| **\*required to process insurance Claims** |
| **I authorize Anchor to Hope Counseling, LLC to release any and all medical information deemed necessary for the purpose of processing insurance claims on my behalf. I understand that I am responsible for all charges not covered by insurance. I authorize the assignment benefits for all covered claims to be paid directly Anchor to Hope Counseling, LLC. A photocopy of this authorization shall be considered as valid and effective as the original.** |
| **Signature Date / /**  |

**Your Therapist will complete the diagnosis information**

**Diagnosis**

**PERSONAL AND MEDICAL HISTORY**

***Thank you for choosing Anchor to Hope Counseling, LLC. You will be treated with courtesy and respect and we will do our very best to assist you in any way we can. Today we need your cooperation in giving us information that will assist your therapist with providing effective service delivery. Thank you for taking the time to answer the following questions fully and accurately.***

**Client Name** **DOB**  **Age**

**Reason for scheduling this appointment:**

Do you have any other issues or concerns that you would like your therapist to know about? Please describe:

By **initialing each line below** you are agreeing to the terms and conditions set forth in each of the following sections.

 **CLIENT RIGHTS AND RESPONSIBILITIES**

***As a Client of Anchor to Hope Counseling, LLC you have the right to:***

* Receive counseling services without regard to race, religion, sex, national origin, sexual orientation, age or disability.
* Be treated with dignity and respect at all times.
* Be accepted for counseling only if the agency has the professional staff to meet your needs.
* Be referred appropriately when the agency is not able to meet your needs in a reasonable and timely manner.
* Be referred for appropriate assessment and management of pain.
* Participate in the development of an individualized treatment plan including goal setting, treatment methods and duration of counseling.
* Participate in periodic review of the Treatment Plan.
* Be informed of the cost of the services and receive appropriate care regardless of the source(s) of payment.
* Confidentiality of information as prescribed by law.
* **You are responsible for paying your session fee or copay/deductible at the beginning of our sessions**. A standard session is 45-50 minutes in length unless otherwise arranged in advance.
* **You are responsible for knowing your insurance benefit limitations.** You should contact your insurer directly to determine whether your treatment requires preauthorization, if you have a deductible to meet, and the amount of your copay.
	+ If your insurer requires preauthorization of the first session and you do not obtain it, you are responsible for the full cost of that session.
	+ You are not responsible for the cost of sessions for which I am required to obtain the preauthorization (this usually relates to ongoing treatment rather than the initial session).
	+ You are responsible for notifying me of any changes in your insurance coverage.
* My office is not set up to routinely provide crisis intervention services. In case of an emergency, you may go to your local emergency room or call Respond at (540) 776-1100 or Connect at (540) 981-8181.
* You are responsible for keeping me informed regarding changes in your contact information.
* You are responsible for letting me know if you are dissatisfied with your treatment in any way. I cannot address the problem if I do not know that there is one.
* You are responsible for working at least as hard as I am to address the concerns that brought you or your child to therapy. You will have to work on the things we talk about both during sessions and at home if you want to change.

 ***LIMITATIONS TO CONFIDENTIALITY***

* If your clinician has cause believes that you are likely to harm yourself, he/she may take action necessary to protect your safety by contacting your significant other, law enforcement officers or a physician.
* If your clinician has cause to believe you are likely to harm another person, he/she may take action necessary to protect their safety by contacting the individual that has been threatened, law enforcement or a physician.
* If your clinician has cause to believe a child has been or may be abused or neglected, the clinician is required to make a report to the appropriate state agency.
* If your clinician has cause to believe an elderly or disabled person has been or may be abused, neglected, or subject to financial exploitation, the clinician is required to make a report to the appropriate state agency.
* Information disclosed about a person from whom you sought counseling behaving toward you in a sexually inappropriate manner must be reported (your identity may remain anonymous at your request).
* If your records are requested by a valid subpoena or court order, we must respond.
* If you are a minor (under the age of 18)

 **CANCELLATION AND NO-SHOW POLICY**

* An agreement will be made between therapist and client/parent(s)/legal guardian regarding the frequency of therapy.
* The frequency of therapy will be developed with the intent of maximizing the therapeutic effect of treatment. Cancellations will compromise progress. Also, cancelled appointment times can be given to other patients.
* When the need arises to cancel an appointment, we request notification as soon as possible, but preferably within 24 hours before the scheduled appointment time if possible.
* Canceling or no showing for **three** scheduled appointments will result in losing you/your child’s appointment times and the charge of a $50 per missed appointment fee. Please note that clients with Mediciad Insurance will not, by law, be charged a fee.
* Therapist cancellations will not count against client.

Client Signature Date

Client Printed Name