Anchorpoint Counseling, LLC

Verena Burger Schmid, LPC, CACII; 831 Royal Gorge Blvd #228, Cañon City, CO 81212
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CLIENT REGISTRATION

Client's Full Name: _____ **Date of Birth**: _____
SSN #: _____ **Gender:** M___ F___ Other:_____
Is the client a minor (under age 18) child? YES___NO ___ **Custodial Parent's Name:** _____
Street Address: _____ **Home Phone:** _____
City, State, Zip: _____ **Cell Phone:** _____
E-mail: _____ **(optional)**
Marital Status: Married ___ Never Married ___ Domestic Partnership ___ Separated ___ Divorced ___ Widowed ___
Client's Occupation: _____ **Employer:** _____
Work Phone: _____ **Student/ School:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____
Phone #s: _____
Name of PRIMARY CARE PHYSICIAN _____ **Phone #:** _____
PRIMARY INSURANCE Name: _____ **Phone #:** _____
Name of Insured: _____ **SSN #:** _____
DOB: _____ **ID #** _____ **Group #** _____
Address: _____
Employer: _____ **Work Phone:** _____
Relationship to Client: _____
SECONDARY INSURANCE Name: _____ **Phone #:** _____
Name of Insured: _____ **SSN #:** _____
DOB: _____ **ID #** _____ **Group #** _____
Address: _____
Employer: _____ **Work Phone:** _____
Relationship to Client: _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR/Insurance Holder) INFORMATION

If same as client, please complete only Questions #1 and #3 of this section

1. Guarantor Name: _____ **DOB:** _____
2. Address: _____ **Phone #:** _____
3. Driver's License #/ State: _____ **SSN#:** _____
4. Guarantor's Relationship to Client: ___ Spouse ___ Mother ___ Father ___ Sibling ___ Relative/Friend
___ Legal Guardian ___ Other: _____
5. Guarantor's Employer _____ **Work Phone# :** _____
Occupation: _____

Please read carefully and sign to attest to your agreement:

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to: **Anchorpoint Counseling, LLC/Verena Burger Schmid, LPC, CACII** the amount due for services rendered to my dependent and/or me.

RELEASE OF INFORMATION: I authorize the release of any medical, behavioral health and/or substance abuse information necessary to process insurance claims for services rendered to my dependent or me. This consent may be revoked at any time in writing, except where action has already been taken on the basis of this release. This release will expire automatically six months after the final payment has been received in my account. This Release is subject to State and Federal confidentiality requirements.

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for all services rendered by provider **Anchorpoint Counseling, LLC/Verena Burger Schmid, LPC, CACII**. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, deductible and any non-covered services as identified in the disclosure statement.

CLIENT RELEASE OF INFORMATION TO GUARANTOR/THIRD PARTY AGENCY: I authorize **Anchorpoint Counseling, LLC/Verena Burger Schmid, LPC, CACII** to release information to my Guarantor or a Third Party Collection Agency (for outstanding balances after 60 days, with collection charges added).

_____

Client/Parent/Legal Guardian/Guarantor / Signature (Circle what applies) **Date**

Please fill out the back ➡

CONSENT TO TREAT

Client Full Name: _____ Date: _____
DOB: _____

I consent to the outpatient mental health evaluation and treatment recommended by **Anchorpoint Counseling,LLC/Verena Burger Schmid, LPC, CACII**. I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

FEE AGREEMENT (Please read and initial all)

____ As a self-pay client, I agree to be responsible for payment at the time of each assessment/therapy session in the amount of _____. I become a self-pay client when my insurance becomes inactive.
____ I have _____ insurance and agree to be responsible for my co-payment, co-insurance and/or deductible (if applicable) and pay it at the time of each intake/therapy session in the amount of _____.
____ I agree to pay a case management fee of $35 for all non-routine phone calls, emails, or letters/reports written on my behalf to an authorized third party. I understand that these fees will be billed directly to me, not my insurance company.
____ I agree that if my check does not clear the bank I will be responsible for an additional fee of $25.
____ I agree to be responsible for payment of the full fee of $110 for any missed appointments or appointments cancelled with less than 24 hours advance notice (except for documented emergency situations). **Not applicable to active MEDICAID clients.**
____ I give my permission for outstanding balances to be reported to a collection agency after 60 days, with collection charges added.
I understand that these fees will be billed directly to me, not my insurance company.

_____ Date: _____
Client/Legal Guardian/Guarantor Signature (Circle what applies)

_____ Date: _____
Verena Burger Schmid, LPC, CACII
Anchorpoint Counseling, LLC

If client is a MINOR, please complete this section. Fill in all that applies.
Birth Mother's Name: _____ Step Father's Name: _____
Birth Father's Name: _____ Step Mother's Name: _____
Who brought minor child for counseling? _____
Who is the legal guardian for the minor client? _____
What is your relationship to minor client if none of the above? _____ _____
If a divorce or a temporary order determines physical and legal custody, medical decision making power of attorney etc., please provide a copy of it as soon as possible, particularly if one parent is sole conservator.
If applicable, who is the sole conservator? _____
Please list all members of your household:
Relationship/Age/ Gender
1. _____
2. _____
3. _____
4. _____
5. _____
Family Members to be involved in treatment: _____