Client Information Form

(Please Print)

Client First Name_______________________________ Last Name_________________________________ Date ___________

Address ____City ___________________________________State ________

Zip___________ Phone (H __W __C__) ___________________________ Phone (H__W__C__)________________________

Social Security#____D.O.B.________________________________Age __________

Sex M _____ F_____ Marital Status S___ M___ Sep ___ D___ W ___

Church Affiliation (if any) ____________________________Denomination _________________________________

Emergency Information

Emergency Contact Name ____

Relationship______________________________Address____

City_____________________________________ State________________ Zip ______________________________

Cell Phone _____________________________________Alternate Phone ___________________________

Insurance Information

PRIMARY Insured ____

DOB______________________________SS#___________________________________

Relationship to Client _________________________________ Employer ___________________________________

Primary Insurance Carrier ________________________________ Phone ___________________________________

ID# ____Group _______________________________________

SECONDARY Insured ____

DOB__________________________________SS#___________________________________

Relationship to Client ___________________________Employer_______________________________________

Secondary Insurance Carrier _________________________________Phone ________________________________

ID # ____Group ____

Insurance Authorization and Assignment of Benefits

I hereby authorize Steve Augustus, LCPC to furnish client diagnosis and treatment information to the client's insurance carrier(s) and request the client's insurance carrier(s) to direct payments to Steve Augustus, LCPC

Client's signature: ____Date: __________________________

Confidentiality and Authorization of Treatment

All information regarding the client is considered strictly confidential and will not be shared without the client's or authorized person's written consent. Exceptions are listed in the Notice of Privacy Practices which will be presented at time of the first session. In the event of a request for the transfer of records to another party, such records will be forwarded directly to that party only upon the receipt of your written request.

I give my consent to Steve Augustus, LCPC to provide evaluation and treatment that we may mutually determine to be appropriate. I am participating in treatment voluntarily and understand I have the right to refuse or discontinue treatment at any time.

Client signature ____Date:___________________________

Acknowledgement of Receipt of Notice of Privacy Practices
(this section to be filled out at first session)

I (print name) ____have been presented with a copy of the Notice of Privacy Practices explaining how my information may be used and disclosed as permitted indoor federal and state law, and I understand the contents of the Notice.

Please check one:

_______I have received and read a copy of the Notice of Privacy Practices.

_______I decline receiving a copy of the   Notice of Privacy Practices.

Client signature ____ Date ___________________________

Office Fees and Policies

Insurance Clients
As a service to you, whenever your insurance will work with me I will process your insurance claims. Benefits payable are determined at the time the claim is processed. Insurance quotes by me are not a guarantee of benefits. That is determined by the insurer alone. If you have questions regarding your benefits please call your insurance company directly. If insurance does not pay, all charges will be the responsibility of the client.

Copayments are due at the time of service. It is the clients responsibility to notify me within a timely manner if your insurance carrier changes

NSF Checks There will be a $15.00 charge for any returned checks due to non-sufficient funds.

Cancellation/ No Show Policy It is the clients responsibility to notify me 24 hours in advance when canceling an appointment. If 24 hours are not given by the client, a $50 Late Cancellation/ No Show fee will be charged. This fee is not covered by insurance and will be billed to the client directly.

Telephone Calls After the first session, phone calls lasting more than 5 minutes with me will be billed to the client. Clients will be billed $1.00 for each additional minute over the first 5 minutes.

Completion of Forms/ Letters/ Requests for Written Reports Completion of forms, letters and/or written reports requested by clients will be billed at $25.00 for up to 2 pages. Additional pages will be billed at $10.00 per page. This fee is not covered by insurance and will be billed directly to the client. Please allow10 business days for the completion of requested forms/letters/written reports.

Records Requests To fulfill an order for a records request a signed Release of Information form must be completed and submitted to me. A fee of $25.00 will be charged for all records requests. Please allow 10 business days from the receipt of the Release of Information form for the request for records to be fulfilled.

Financial Responsibility Account balances that remain unpaid for more than 90 days will be forwarded to a collection agency. The client will bear the full cost of collection activity.
I accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, Personal checks and cash as forms of payment.

I have read and understand the above policies and agree to abide by them.

Client or Financial Responsible party for the client

(Please print name) ____

If above name is not that of the client the relationship to the client is:___________________

Address___________________________________City_________________State_______

Phone____H___W___C_____________________________________

SS#_____________________________________DOB_________________________

Signature____Date____________________
(**must match printed name above)**