**Counseling Associates of Aiken**

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| **Client Demographic Information** |

Provider You Are Seeing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (First, MI, Last):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Cell Phone:( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message or text? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Birth Date:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employment:\_\_\_\_Full Time \_\_\_\_\_\_Part Time \_\_\_\_\_\_UnEmployed

Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:\_\_\_\_Cohabitating\_\_\_\_Divorced\_\_\_\_Engaged\_\_\_\_Married\_\_\_\_Seperated\_\_\_\_Single\_\_\_\_Widowed\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Okay to send email?\_\_\_\_Yes\_\_\_\_No

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we contact?\_\_\_\_\_\_Yes\_\_\_\_\_\_No

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financially Responsible Person:(If different from client)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender\_\_\_\_\_\_\_\_\_Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Insurance Information** |

Primary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counseling Associates of Aiken**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Notice of Privacy Practices** |

I hereby acknowledge that I have been given an opportunity to read a copy of Counseling Associates of Aiken’s Privacy Practices. I understand that if I have any questions regarding the Notice of my Privacy Rights, I can contact Teresa Barden at 803-226-0190 for further information.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

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| **Authorization for Release of Information Necessary for Processing Claims and Payment** |

I hereby authorize release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to this practice for the services rendered. I understand I will be responsible for the difference between charges allowed and insurance payment (i.e Medicare allowances, managed are fee schedules, deductibles, etc.)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Counseling Associates of Aiken**

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, we have corresponding responsibilities to you.

**Our Responsibilities to You as Your Therapist**

**I. Confidentiality**

With the exception of certain specific exceptions, you have the absolute right to the confidentiality of

your therapy. We cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. We have outlined this in more detail in our Privacy Practices.

**II. Other Rights**

You have the right to ask questions about anything that happens in therapy. We’re always willing to discuss how and why we’ve decided to do what we’re doing, and to look at alternatives that might work better. You can feel free to ask us to try something that you think will be helpful. You can ask us about our training for working with your concerns, and can request that we refer you to someone else if you decide we’re not the right therapist for you. You are free to leave therapy at any time.

You will be involved in the planning process of an individual plan of care (IPOC). You may request a copy of the IPOC at any time.

**III. Our Role and Limitations to that Role**

Our role as a therapist is to promote healing and growth. To protect that relationship and the emotional safety of the clinical environment. We do not become involved in legal matters such as custody, placement recommendations, or testify as an expert witness.

**Your responsibilities as a Therapy Client**

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person’s session. If you are over 15 minutes late for your appointment, that appointment will need to be rescheduled. If you miss a session without canceling, or cancel with less than twenty-four hour notice, it will be considered a no show. If you no-show for two sessions in a row and do not respond to my attempts to reschedule, we will assume that you have dropped out of therapy and will make the space available to another individual.

You are responsible for paying your session weekly unless we have made other firm arrangements in advance.

If you have insurance, you are responsible for providing us with the information we need to send in you bill. You must pay us your deductible at the beginning of each calendar year, if it applies, and any copayment at each session. We will bill directly to your insurance company for you via electronic means. You must provide us with your complete insurance identification information, and the complete address of the insurance company. If the insurance overpays us, we will credit it to your account or refund it to you, if you prefer.

We reserve the right to refer you to another practice if we do not, we assess that we are the appropriate resource. We expect appropriate behavior and respectful interactions with all staff. If you engage in inappropriate behavior, we will refer you to another practice.

If your outstanding balance is higher than $200.00 we may discontinue therapy and provide a referral to another therapist.

We will charge $100.00 no show fee for appointments not cancelled at least 24 hours in advance of the appointment time.

There is a $25.00 charge for filling out paperwork. Please allow a two week notice for the competition of this paperwork.

**Client Consent to Treatment**

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits of confidentiality required by law. I consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process. I agree to pay the fee of the $100.00 per session through either insurance coverage or as a self-paying client. I understand my rights and responsibilities as a client, and my therapist’s responsibilities to me. I know I can end therapy at any time I wish and that I can refuse any request or suggestions made by my therapist. I am over the age of thirteen.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_