Client Information

(Informed Consent and Confidentiality)

Client Name: ____

Social Security #: _______________ Date of Birth: ______________ Race: ______________

Address: ___________________________ City: _____________________ Zip: __________

Phone: (cell) __________________ (home) __________________ (work) __________________

May we leave a message? Cell: Y/N Home: Y/N Work: Y/N

Email:(only if we may contact you through email) ______________________________________

Would you like access to our Client Portal ? Y/N

Occupation/Employer: ____

Married _____ Separated _____ Divorced _____ Widowed _____ Never Married ______

Spouse (if applicable): ____

Children/Siblings (if minor) **names & ages:**

____

____

If Client is a Minor:

Custodial Parent/Guardian:______________________DOB:___________Phone:______________

As the Custodial Parent/Grardian, I have reviewed and signed the Custody Addendum Form? **Y/N**

Person Responsible for Payment and Insurance Information:

Name/Primary Insurance:____

Address: ____

Phone: ____

Policy Holder: ______________________________________ DOB: ____________________

Plan Number: ____ Group #: _______________________

Employer: ____

EmergencyContact:____Phone: ___________________

I give consent for insurance to be billed for services rendered. Y/N

I understand that I am responsible for payment of services not covered by insurance. Y/N

I have reviewed the Policies and Practices to Protect the Privacy of Your Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA)? Y/N

[You may request a copy of the Policies and Practices to Protect the Privacy of your Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA)]

I authorize the counselors and the staff of WFCC to release the following information to the following people as listed below:

____

Name Relationship Phone

Please Circle: Appointment Date & Time Financials Counselor

____

Name Relationship Phone

Please Circle: Appointment Date & Time Financials Counselor

____

Name Relationship Phone

Please Circle: Appointment Date & Time Financials Counselor

( ) I do not authorize Wabash Friends Counseling Center to release any information to others. I understand I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released).

Please initial each line of the Service Guidelines

(Minors who are 14-17 yrs. old must initial each line along with the parent/guardian's initials.)

_____ I understand that Wabash Friends Counseling Center (WFCC) does not have an outpatient emergency response system. I must not leave emergency messages on voicemail, as these may not be heard until the next scheduled business day. If I need emergency services, I must call or go to the nearest Emergency Room for assistance.

_____ I understand that a standard session time is fifty minutes in length.

_____ I understand I have made a voluntary choice to be involved in counseling provided by a mental health professional as defined by Indiana State Law. I understand counseling is a cooperative effort between me and my counselor. I am free to terminate counseling at any time.

_____ I understand that through counseling I may change and the relationships around me may change. Counseling often involves talking about and expressing intense and possibly painful emotions. Therefore, it may get harder before it gets easier. I understand that while resolving unpleasant current and past situations, I may have moments of discomfort and a temporary increase in emotional pain. I understand that I may discuss any questions or concerns I have about the risks and benefits of counseling with my counselor.

_____ I understand that WFCC is not responsible for children left unattended in the waiting area. If I must bring a child(ren) to my appointment with me, I am responsible for their safety and for them remaining in the lobby.

CONFIDENTIALITY

_____ I understand my treatment will be kept in confidence and is protected by Federal Law and regulations. Generally, WFCC cannot acknowledge to anyone that I am receiving treatment. A release of information will only occur by my informed, signed, and witnessed consent. The only exceptions are those required by law, including but not limited to: suspected child abuse/neglect (which will be reported to appropriate state or local authorities), danger to self or others, a court order, and in the treatment of minors to biological parents (except those minors being treated for substance abuse in reference to Indiana Law 42 CFR 2.14). I also understand my appointments may be discussed with a licensed supervisor or during regular staffing.

_____ I understand that WFCC cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email regarding scheduling or cancellations, we will do so. While we try to return messages in a timely manner, we cannot guarantee immediate response. ***Electronic communication will not be used to conduct counseling sessions and should not be used to request emergency services.*** We are also ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, WFCC must comply.

_____ I understand that WFCC's policy does not allow our counselors to "*friend*" or "*follow*" current or recent clients on Facebook, Twitter, or other social media platforms. WFCC feels it is not in the best interest of our clients to engage with them on social media and puts the ability to maintain confidentiality at risk.

_____ I understand that while I am at WFCC, I will help maintain other people's privacy by refraining from taking pictures or making recordings of any kind. I will also silence my phone while in session. This will help me make the most of my session.

_____ I authorize WFCC to release necessary medical information to appropriate third parties, i.e. insurance companies and Medicaid, for reimbursement purposes and/or to persons authorized to conduct service reviews and audits.

_____ I authorize my counselor to contact my Primary Care Physician (PCP) to coordinate services.

FEES/CANCELLATIONS

_____ I understand and agree that I am personally and fully responsible to pay for all services rendered. If I have insurance with a WFCC contracted carrier, they will file claims on my behalf. However, I'm responsible for any co-payments or other payments which are not covered by my insurance carrier**. In the event my account becomes overdue and is sent to collections, I understand that I will be responsible for 18% interest, any court costs, and reasonable attorney fees.**

_____ I understand the insurance benefits quoted by my insurance company and/or WFCC **are not** a guarantee of payment.

_____ I understand that if I do not have insurance or choose not to have my insurance billed, I can make payments according to the sliding scale offered, which is based on my annual household income. I understand I must provide proof of income, i.e. a copy of my current tax form or a copy of my 3 most recent pay stubs from my employer at my first scheduled appointment. If I have any changes in my income, proof of income must be provided again. I must send the proof of income via mail, email, fax or bring it in person to the Wabash Office. I will be charged the full fee of $150 until I have provided my Proof of Income to WFCC. An additional $20 will be billed for the initial (first session) and yearly intakes.

_____ I understand payment for counseling is due at the time of the counseling session. No cash will be accepted at the Satellite offices (Kokomo and Marion). Checks should be made payable to *Wabash Friends Counseling Center (WFCC)*. We also accept Visa, MasterCard, and Discover. If you miss two payments, we will not be able to reschedule you until we receive your full payment. Checks returned for non-sufficient funds are charged $25.

_____ I understand that I am responsible to give at least 24-hour notice when canceling appointments. If I have two consecutive late cancellations or two consecutive no shows, I may be terminated as a client.

_____ I understand that I may be charged a fee of $20 for late cancellations (less than 24-hour notice). For no-shows, I may be charged the full fee if I have insurance. If I do not have insurance, my fee for no-shows will be determined by my sliding scale fee. In case of emergencies, i.e. unexpected weather or illness, I will not be charged.

_____ I understand that I have the right to voice a disagreement or concern to any staff person in order to resolve an issue. If a resolution is not acceptable to the client, the client may file a formal complaint on the Client Grievance Form and submitted to the Director of WFCC. WFCC will investigate the complaint and respond to the formal submitted grievance within 10 working days. *If there is no resolution, the client can file a report by phone to the Division of Mental Health and Addictions Consumer Service Line at 800.901.1133.*

_____ I understand and agree to the above policies and procedures. A full copy of the Notice of Privacy Practices is available upon request or online at www.wabashfriendscounseling.com.

Client's Signature: ____ Date: ____________

(Minors who are 14-17 yrs. old must sign above.)

Parent/Guardian's Signature: ____ Date: ____________

Witness Signature: ____ Date: ______________