INSURANCE INFORMATION SHEET

It is important that you thoroughly complete this form and provide a copy of both sides of your insurance card(s). Thank you.

Therapist's Name: ____________________

CLIENT INFORMATION

Name:		Birth Date:
Address:		SS#:
City:	State:	Zip:
Home Phone:	Mobile Phone:	
Employer:		
Is client a dependent child? Yes or No	Martial Status: (Cirlce one) M S Other	

PRIMARY INSURANCE INFORMATION

Who is the Insured:	SS#:	Birth Date:
Employer of Insured:	Work Phone:	
Insurance Co.:	Policy #:	Group #:
Customer Service Phone:	Mental Health Phone:	

DO YOU HAVE SECONDARY INSURANCE? Yes or no

Who is the Insured:	SS#:	Birth Date:
Employer of Insured:	Work Phone:	
Insurance Co.:	Policy #:	Group #:
Customer Service Phone:	Mental Health Phone:	

DO YOU HAVE EAP? Yes or no

Name of EAP:	Phone # of EAP:		
Authorization #:	Sessions Authorized:	From	To

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that HCCC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold HCCC liable for insurance nonpayment due to misquoted benefits. I acknowledge I am responsible to know and understand my benefits plan. HCCC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request assigned benefits be paid to HCCC and/or the provider indicated above.

Signature of Client and/or Insured:______________________ Date:_______________

CLIENT'S PERSONAL DATA

Today's Date: ____________________

Client's Name: ____
Birth Date: __________________________ **Social Security #:** __________________________
Is the client a minor (under age 17) child? YES_________ NO ___________

Street Address: ____ **Home Phone:** ______________________________

City, State, Zip: ____ **Work Phone:** ______________________________

Driver License #:_____________________ **Cell Phone:** ________________________________

Other Phone: ______________________________

Marital Status: **Married** (No. of years): _______ **Single:** ______ **Separated** (since): _________ **Divorced** (since): __________

Education (last year completed): ______________________________ **Degree:** ____

Client's Occupation: ____ **Employed by:** __________________________________

If client is a **minor** complete this section. Fill in all that apply.

Birth Mother's Name: ______________________________ Step Father's Name: ____________________________
Birth Father's Name: ______________________________ Step Mother's Name: ___________________________

Name of responsible party: ____
Street address of responsible party: ____
City, State, Zip: ____

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 divorce or a temporary order has precipitated arrangements, please provide a copy ASAP, particularly if one parent is sole conservator. If applicable, who is the sole conservator? ____

Please list all members of your household:

Name- Relationship	Birth Date- Age	Sex
1.		
2.		
3.		
4.		
5.		
6.		

EMERGENCY CONTACT INFORMATION

Who would we contact in case of an emergency? Name / Phone #:____

Name / Phone #:____

SPIRTITUAL INFORMATION

Do you consider yourself a Christian? YES ________________________ NO ____________________

My relationship with God is ____

____.

Do you desire prayer and/or Bible reading as part of your counseling? YES ________________ NO ________________

Church Denomination: ____

What church do you attend? ____

How often do you attend worship services? ____

MEDICAL INFORMATION

Name of Primary Care Physician: ____ Phone #:___________________________

List any medical conditions: ____

____.

Are you currently on any medications? YES ____________ NO _____________

If so, please identify medication, dosages and times taken: ____

____.

Are you allergic to any medications? YES ____________ NO _____________

If yes, what are they? ____.

ALCOHOL / DRUG HISTORY

	YES	NO	MAYBE
1. Do you drink alcoholic beverages?	_______	_______	_______
2. Have you or a family member ever been concerned about your alcohol usage?	_______	_______	_______
3. Have you ever been concerned about another family members' alcohol usage?	_______	_______	_______
4. Do you have a history of illegal drug use or prescription abuse?	_______	_______	_______
5. Have you or a family member ever been concerned about your illegal drug use or prescription drug abuse?	_______	_______	_______
6. Have you ever been concerned about another family members' illegal drug use or prescription drug abuse?	_______	_______	_______
7. Do you smoke cigarettes or other tobacco products?	_______	_______	_______

LEGAL DATA

Are there any legal cases pending? YES _________________ NO ___________________

Briefly describe the nature of those cases: ____

COUNSELING DETAILS

Briefly describe your current difficulty: ____
____
____
____
____
____
____
____
____.

What are your goals you hope to achieve through counseling? ____________________________
____
____
____
____
____
____
____.

Have you ever been to counseling before? YES _____ NO ______ **Support/ Recovery Groups:** YES _____ NO _____

If yes, identify counselor and the dates: ____
____.

Briefly explain the nature and outcome of that counseling: ______________________________
____
____
____
____
____
____.

FOR OFFICE USE ONLY: ____
____
____
____
____
____
____

Professional Services Agreement

We are pleased that you have chosen Houston Center for Christian Counseling (HCCC). This form gives you some information about our professional relationship. Your appointment is with the therapist whose name appears at the top of Page 1. You are encouraged to ask him/her any questions regarding their background, credentials, professional experience or philosophy.

CONFIDENTIALITY INFORMATION

HCCC is concerned about confidentiality. As Christian counselors, we believe God expects us to be trustworthy and we believe it is God's will for His people to know safety and security. It is the goal of HCCC to provide an environment in which our clients may place their trust and confidence. Under both federal and state law, confidentiality means communication with your therapist and any records pertaining to your identity, evaluation, or treatment will be held in confidence. Where federal and state laws differ, we comply with the stricter standard to insure that your right to confidentiality is respected at all times. Also, beyond the law, we know that a sense of safety and security are necessary to the process of healing in which our clients are engaged. Holding to God's law as stated in His Word and by complying with federal and state laws, HCCC will maintain confidentiality to the fullest extent personally and professionally. You have a right to confidentiality.

Our Confidentiality Policy and Privacy Practices Brochure is the bi-folded blue document you have received with this agreement. It is your copy to keep. It states more fully our policies and practices and your rights therein.

Please read the document before signing this agreement.

If you believe the Confidentiality Policy and Privacy Practices document does not answer all your questions regarding confidentiality, talk with your therapist about any concerns you may still have.

Your signature at the end of this document indicates consent to use your personal health information for routine practices according to the law for treatment, payment, and health care operations. You may revoke this consent in writing at any time, except to the extent that HCCC has taken action relying on this consent.

RIGHTS & RESPONSIBLITIES

Rights

You have a right to be provided with professional and respectful care. You have a right to know your therapist's assessment of the problem, the recommended treatment, and resources available to help deal with your situation.
You also have the right to refuse our suggestions.

Responsibilities

1. To be honest, open, and willing to share your concerns
2. To ask questions when you don't understand or need clarification
3. To discuss any reservations you have about your treatment plan
4. To follow the agreed upon treatment plan
5. To report changes or unexpected events related to your problem
6. To keep appointments whenever possible or to call and cancel within 24 hours prior to your appointment. (see payment information – you will be charged the entire session fee for appointments not cancelled with 24-hour notification)

Remember, you are responsible for your thoughts, feelings, actions, and growth. We are here to help facilitate that growth to the best of our ability.

PAYMENT INFORMATION

The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professional services.

The fee for the initial 50-minute therapy session is $135.00. The fee for all follow-up sessions is $125.00. It is the same for individual, couple, or family therapy.

Payment is expected at the time of service.

As a courtesy, HCCC will file your insurance claims with your signed consent. HCCC charges for missed appointments. HCCC charges full fee for appointments that are not cancelled with 24-hour notification. Each of these payment requirements are discussed below.

Insurance

1. If you have managed care or employee assistance through your employer or through a private policy, HCCC will file your insurance with your consent. Sign the insurance information sheet if you wish us to file as a courtesy to you.
2. Co-payments must be made at the time of service. Deductibles amounts are due at the time of service.
3. If you are seeing a provider that is in your managed care network (In Network), your fee will be the negotiated rate as stated in the contract between the network and your therapist.
4. If you are seeing a provider that is not in your managed care network (out of network), you are responsible for amounts your insurance does not pay up to $135.00 for in the initial session and $125.00 for follow up sessions.
5. For clients using Employee Assistance (EAP), there is no charge for a set number of authorized sessions.
6. If you authorize this office to file insurance by your signed consent, we will do so, but you must understand that you insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and insure your carried remit payment. If a problem occurs with your claim, you will be required to make payment or establish a written financial payment plan with our office until your insurance problem is resolved.

Financial Payment Arrangements

1. Each month you will receive a monthly statement for services, which is due and payable within 30 days. If your payment is late, then we will mail a reminder notice. All patients refusing to remit payment after 60 days of notice will force us to limit their future credit until the previous balance is paid in full, or until a written legally binding, financial payment plan document has been executed. If you are experiencing a set of circumstances out of your control, please talk with your therapist, the office manager or her representative; and we will establish a mutually agreeable financial payment plan. Please notify us immediately if a mistake appears on your statement.
2. After **60 days** and after notification, delinquent accounts will be turned over to a collection agency and the client will be responsible for collection fees of 33% in addition to any unpaid balance on the account.
3. There is a $35.00 service charge for returned insufficient fund checks. Insufficient checks are deposited twice. If the second deposit is also insufficient there will be an additional $35.00 service charge. After the second insufficient deposit we will only accept cash for payments for services rendered until the insufficient check and service charges are paid in full.

PAYMENT INFORMATION (continued)

APPOINTMENT CANCELLATION POLICY

Twenty-four hour (24) notification is an expected courtesy to the therapist who is reserving time for you and to other clients who are waiting to schedule appointments. You must give 24-hour advance notification for cancelled appointments. The advance notice is standard in our profession.

If you miss an appointment without 24-hour notification, you will be charged the entire session fee of $125.00. **If you do not notify us 24-hours in advance when canceling an appointment, you will be charged the entire session fee. Insurance plans rarely pay for such charges.**

HCCC has a 24-hour answering service to assist you in canceling appointments in a timely manner.

1. You will receive written notification of the missed appointment and a bill for the agreed upon amount within a few days of the previously scheduled appointment time. If you think there is an error, contact our office immediately.
2. You must pay for the missed appointment charge in full at your next scheduled visit OR make a partial payment and arrange a payment plan.
3. Payments must be made in addition to other co-pay amounts or deductibles that may be due on subsequent visits.
4. Payment must be timely or we **cannot** continue to schedule appointments.

SIGNATURE FOR PROFESSIONAL SERVICES AGREEMENT

I do voluntarily agree to participate in the assessment and counseling as offered by Houston Center for Christian Counseling. I am aware that treatment often involves family therapy or education which will be recommended if the therapist deems it important to the healing process. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in this document.

I consent to the use of my personal health information for routine practices for treatment, payment, and health care operations according to the laws of the State of Texas and the Federal government as outlined in the Confidentiality Section of this document and discussed in detail in the Confidentiality Policy and Privacy Practices Brochure.
I have received a copy of this Brochure.
I have read and agreed to the payment information as stated in this document.

I understand I will be charged $125.00 for appointments that are not cancelled within 24-hours or for appointments I miss altogether.

By my signature below, I accept all the terms and conditions as herein stated.

Client's Name: ____

Client's Signature: ___________________________ Date: _______________

*Parent/Guardian's Signature ____________________________ Date: ________________

*(required if client is 17 or under-in some cases the therapist may require legal documentation of guardianship of children 17 or under)

HOUSTON CENTER FOR CHRISTIAN COUNSELING

www.christiancounselinghouston.com

402 Julie Rivers Drive
Sugar Land, Texas 77478
Phone: 281-277-8811
Fax: 281-277-8827

609 Park Grove Dr. Unit B
Katy, Texas 77450
Phone: 281-398-0022
Fax: 281-578-6622

Client's Name:_________________________ Therapist's Name:_________________________

HOW DID YOU HEAR ABOUT US?

________ Church

Which church? _______________________________________

Which pastor? _______________________________________

________ Personal Friend

________ Insurance company list

________ Employee Assistance Program through your employer

________ Website

________ Ad   Where did you see the ad? ___________________________

________ Doctor   What is the Doctor's name? ___________________________

________ Phone Book

________ Brochure

________ Other   Please specify _______________________________________

Thank you!

PERMISSION TO CONTACT YOU BY E-MAIL

From time to time we may contact you via e-mail about appointment times with your permission. We will always be discreet; the name of this office will not be used in our correspondence. For example, we would say, "Reminding you of your appointment with (therapist name) on Tuesday, March 17th at 2:00pm. Please call 281-277-8811 to confirm, cancel, or reschedule." To assure absolute confidentiality, we will correspond via e-mail ONLY about appointment dates and times. We will NEVER disclose other information in e-mails even if you solicit a reply pertaining to another matter or issue.

I give my permission to contact via e-mail.   YES_____________   NO_____________

We have an e-mail newsletter that will contain information on various counseling topics.

Do you want to receive the newsletter?   YES_____________   NO______________

My e-mail address is: ____

Optional second email: ____

Signature _______________________________________

Date ____

Confidentiality Policy and Privacy Practices

Houston Center for Christian Counseling (HCCC) is concerned about confidentiality. We believe a sense of safety and security is necessary to the process of healing in which our clients are engaged. It is the goal of HCCC to provide an environment in which our clients believe they can place their confidence and trust.

Under both federal and state law, confidentiality means communication with your HCCC therapist and any records pertaining to your identity, evaluation and treatment will be kept secure and private. Where federal and state law differs, we comply with the stricter standard to ensure that your right to confidentiality is respected at all times.

Examples of disclosure allowances under federal and state law for treatment, payment and healthcare operations are as follows:

- The therapist will disclose necessary information and notify authorities and other third parties when there is reasonable suspicion a minor child (under 17 yrs), an elder person (65 yrs and older), or otherwise dependent adult (any age) has been harmed.
- The therapist will disclose necessary information and notify authorities or other appropriate parties when the client has directly admitted serious and imminent suicidal threats.
- The therapist will disclose necessary information and notify authorities or other appropriate parties when the client has directly admitted harmful acts or threatened action that is serious, imminent and attainable against a clearly identified third person or persons.
- Therapists may be required to make disclosures to insurance and third-party payers, employee assistance programs and managed care groups concerning client's diagnosis, session dates and where required, client symptoms and treatment objectives.
- Client communication and records must be disclosed when ordered by the court.
- Exceptions to confidentiality are made in specified civil law cases such as disclosures relevant to a parent-child relationship, e.g. , in a divorce action.
- If a client files a malpractice suit or a formal complaint with their licensing board against a therapist, confidentiality is waived.

Other issues relative to confidentiality that may be applicable in specific instances follow:

- Graduate Interns receive supervision from HCCC therapists to facilitate their development and to ensure excellent care for our clients. In these instances, written or other legal authorization has been obtained from the client and client identities are protected.
- Written records of client communications are stored in a way to protect confidentiality and privacy rights. Electronically stored records are protected by password restrictions, backup systems, virus security software and firewall protection.

A federal program called Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to put into writing any request you believe necessary to restrict possible misuse of your protected health information. All requests will be honored expect as the law specifically outlines the use of your personal health information for treatment, payment and healthcare operations.

HIPAA states once you give consent for the use of your personal information for treatment, payment and healthcare operations by signing the professional service agreement, you may revoke the consent in writing at anytime, except to the extent that HCCC has taken action relying on your prior consent. If we believe we cannot honor your written request for restriction of healthcare information, we will discuss our reasons with you and if necessary, terminate our professional agreement formally in writing.

Under HIPAA, you have the right to request in writing, receive and inspect copies of confidential protected health information held in this office. HIPAA has guidelines regarding what information must be included in response to a request from a client. If the information you request is outside those guidelines, we have the right to deny your request. Requests within the guidelines will be honored; however, there is a reasonable charge for labor and copying, and reasonable time for preparation must be allowed.

Under HIPAA, you have the right to amend any of your protected health information by a written request. If your written request is outside the laws' guidelines, we have the right to deny your request to amend records.

If you believe we do not follow the stated intentions laid out in this document and/or you believe your right to confidentiality has been violated, please talk with your therapist or the Center's office manager or director. If you wish, you may file a written complaint with our office. Address your concerns to:

Houston Center for Christian Counseling
Attn: Director
402 Julie Rivers Drive
Sugar Land, Tx 77478

If there is no resolution, you may file a complaint with the Department of Health and Human Services, Office of Civil Rights. For more information about HIPAA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
Telephone: (202) 619.0257
Toll Free: 1 (877) 696.6775