EMERALD COAST COLLABORATIVE SOLUTIONS

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NATIONAL BOARD CERTIFIED COUNSELOR

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NATIONAL BOARD CERTIFIED COUNSELOR

Date: _____

Couples Counseling
Family Counseling
Individual Therapy

"Providing quality care for those struggling with issues that interfere with your well-being and those associated in mind; we offer a combined experience of over 25 years' experience in the counseling and human development profession"

Specializing in welcoming you just as you are and helping you move beyond life's challenges to help you find healing and empowerment.
Serving adults and teens dealing with trauma including, but not limited to, trauma caused by combat, extra-marital affairs, heartbreak, abuse, depression, and anxiety.

Client Information

Name: _____
First Last
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Date of Birth: _____ Social Security Number: _____
Email: _____
Please circle one: Married Divorced Single Widow Child
How were you referred to our office? _____ Internet _____ Friend _____ Phone book _____ Insurance _____ Other: _____
May we call or email to confirm your appointment? _____
May we leave a voicemail? _____

Parent/Spouse Information

Name: _____
First Last
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Date of Birth: _____ Social Security Number: _____
Email: _____

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or plans to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has abused a child (or vulnerable adult), or in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature: _____ Date: _____

Insurance Agreement

I understand payment in full is due at the time of service. Emerald Coast Collaborative Solutions is an out of network provider and does not currently accept insurance. However, as a courtesy to you, we will provide you with the necessary documentation for submission for reimbursement as an out of network provider, or we will file on your behalf. We do not guarantee eligibility, coverage, benefits, or reimbursement. Services may be covered in full or in part by your health insurance or employee benefit plan. This would not preclude your responsibility in providing payment for services rendered. We encourage you to contact your insurance provider and ask the following questions:

1) Do I have mental health benefits?
2) What is my deductible and has it been met?
3) How many sessions per year does my health insurance cover?
4) What is the coverage amount per therapy session?
5) Is a referral/authorization required from my primary care physician?

Signature: _____
Date: _____

Insurance Information

Name of Insured Policy Holder: _____
Name of Insurance: _____
Contract Number: _____ Group Number: _____

Credit Card Pre-Authorization

I authorize Emerald Coast Collaborative Solutions to keep my signature on file and charge my credit card as follows:

_____ I understand that my credit card number will remain on file for the duration of my treatment. Should there be a change in the card to be charged, it will be my responsibility to provide a new number immediately. My card will be charged the reserved day of service, and/or should I miss a scheduled appointment without proper 24 hours advance notice.

_____ As noted upon intake, a 24+ hour notice is required in order to avoid being charged. The charge will be either for the co-payment amount or outstanding balance. No-shows will be charged the full rate, which insurance providers will not reimburse.

_____Should cash be preferred, we will also receive cash for services rendered, however, this fee will be required prior to your session. With this arrangement, cash that is unavailable at the time of service will be charged a $10.00 service fee for each outstanding week not paid. If you prefer to pay cash, there are some occurrences that the office will need to contact you, via phone, email, or mail, in order to collect any outstanding balance you may have. If you do not want the office to contact you, a credit card must be on file.

The only exception that would be given would be in the event of an emergency, of which there would be no charge.

Credit Card Type: _____ Visa _____ MasterCard _____ Discover
Account Number: _____
Expiration Date: _____ Security Code: _____
Cardholder Name: _____
Zip Code: _____ Date: _____

Signature: _____

Agreement

_____Emerald Coast Collaborative Solutions has a 24-hour cancellation policy. In the event that you do not call to cancel your appointment within 24 hours of your scheduled appointment, you will be charged accordingly by your therapist. If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed the entire cost of your missed appointment. Thank you for your consideration regarding this matter.

_____I understand that Emerald Coast Collaborative Solutions expects payment in full at the time services are rendered. I understand that my outstanding balance is my responsibility, however, our office will submit insurance claims on my behalf to be reimbursed as requested. Emerald Coast Collaborative Solutions does not guarantee eligibility, coverage, or reimbursement from your insurance provider and recommends you get in contact with your insurance provider.

_____Emerald Coast Collaborative Solutions has a policy that meets government standards for HIPAA (Health Information Portability and Accountability Act) which covers privacy of all medical information. If you desire to read or have a copy of our privacy policy, please request this.

My initials and signature indicate that I have been offered a copy of the Privacy Policy and give this practice the right to file, on my behalf, as a courtesy for insurance reimbursement purposes.

Signature: _____
Date: _____

Please hand these three forms along with a valid photo ID and insurance card to the administrative assistant.