CLARKSON COUNSELING, P.C.

Client Data Form

Client Name _____ _____ _____
Last First M.I.

Age ____ Birthdate _____ Sex____ Social Security # _____

Home Address _____ _____ _____ _____
Street City State Zip

Home Phone _____ Cell Phone _____

Place of Employment _____ Work Phone _____

Relationship Status: ☐ Single ☐Married ☐Partnered ☐Divorced ☐Separated ☐Widowed

Spouse/Partner Name _____ Spouse/Partner SS# _____

Person Responsible for Payment: ☐ Father ☐ Mother ☐ Self ☐ Other

INSURANCE INFORMATION

POLICY HOLDER'S INFORMATION:

Policy Holder's Name _____

Address _____ _____ _____ _____
Street City State Zip

Phone: Home _____ Cell _____ Work _____

Date of Birth _____ Social Security # _____

Ins. ID # _____ Policy/Group # _____

Place of Employment: _____

Employer Address _____ _____ _____ _____
Street City State Zip

Please read and initial each item.

____ Clarkson Counseling is a group practice in which the clinicians meet and consult with one another regularly, thus allowing you to benefit from the expertise of your therapist and the others in the practice. Consequently, your information may be discussed within this practice in order to assist you.

____ Insured clients are expected to take care of their deductibles and/or co-payments as services are rendered. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for your account within the limits of our credit policy. If there is an unpaid balance for sixty (60) days, a $20 late payment charge will be added to the balance. After ten (10) additional days, if no payment has been made, a 25% collection fee will then be added to the balance due, and your account will be outsourced to our collection law firm.

____ Clients will be charged 50% of the normal rate ($30 minimum) for appointments not cancelled 48 hours in advance. Please call if you know you will be unable to make an appointment.

____ I have been offered a copy of this office's client services agreement and notice of privacy practices form. I agree to its terms and conditions.

**** OVER ****

___ We try to be sensitive to our clients' needs and are available for short telephone consultations and writing letters on behalf of our clients to teachers, schools, physicians, other healthcare providers, attorneys, court services personnel, etc. However, phone conversations and clinical work outside of normal sessions that take longer than 15 minutes to complete will be charged at a rate of $30 for every fifteen minute interval. Please note, these charges cannot be billed to your insurance company. Ideally, clinical work/information should be limited to scheduled sessions.

___ What I discuss within the client/therapist relationship is confidential. However, I understand that there are certain situations where my therapist is legally obligated to break confidentiality. These situations include: instances of abuse of children, elders, or persons of disability; life-threatening harm to yourself or specific others; or court-order proceedings.

___ If I choose to utilize my insurance benefits, I am aware that in order for my therapy to be submitted to and covered by my insurance provider, **I MUST MEET THE CRITERIA FOR A MENTAL HEALTH DISORDER AND BE GIVEN A MENTAL HEALTH DISORDER DIAGNOSIS BY MY THERAPIST**. I also realize that once this diagnosis is given to my insurance company, it then becomes a permanent part of my medical record, which could affect future ratings on life and health insurance premiums.

___ By initialing here, you agree to the following statements:

- I authorize payment of insurance benefits to my provider for services rendered.
- I am giving my authorization and consent to receive outpatient diagnostic and treatment services from my provider. I have been given information regarding my rights and responsibilities, limits of confidentiality, and cost of services. I am freely choosing to enter into treatment, and I understand I may discontinue treatment at any time.
- For parents or guardians: I do hereby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.
- I authorize release of any medical or other information necessary to process this claim.

___ I understand that my co-pay is expected at the time of service, and I will be using the following payment options:

☐ cash
☐ check
☐ credit card
☐ debit

If co-pays are not received at the time of service, we will ask for your credit/debit card number to be put on file for processing of subsequent co-pays.

My signature below indicates that I have read and agree to the above statements.

_____ _____

Signature of Client or Guardian of Minor ***Date***