Name: _____ **Date of Birth:** _____ **SS#:** _____ **Intake Date:** _____

TherapyWorks Counseling, PLLC

Client Registration PLEASE PRINT LEGIBLY and FILL OUT FULLY

Information From Insurance Card Date: _____

Insurance Company: _____
Insurance Plan Name or Number: _____ Insurance ID #: _____
Group Number: _____
Name of Insured: _____ Relation to client: _____
Specialist Co-Pay or Co-Insurance: $ or % _____
Provider Phone Number (on back of card): _____
Claim Address (on back of card): _____

☐ I do not have insurance ☐ I have insurance, but wish to file myself.
[Please inform therapist- there is another form to sign in the event you do not wish TWC to file for insurance].

Name: _____ SS #: _____
Address: _____
Phone: Home _____ OK to leave msg Cell: _____ ☐ OK to leave msg/text
DOB: _____ Gender ☐ M ☐ F Marital Status: _____
Email: _____ ☐ OK to email
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Physician: _____ Phone: _____
Guardian Name: _____ Phone: _____

Name: _____ **Date of Birth:** _____ **SS#:** _____ **Intake Date:** _____

TherapyWorks Counseling, PLLC

ADULT INTAKE FORM

Client Rights and Responsibilities

The purpose of counseling is to help you clarify your goals and to achieve greater understanding and skills so you can reach your goals. Much of the success of counseling will depend on your willingness to participate fully in the process of developing goals that are significant to you. Your therapist's role will be to help you develop options for how you want to reach your goals. If you feel dissatisfied with any part of our work together, please let your therapist know immediately so your therapy will be as productive as possible. If you believe you have been treated unethically, by any counselor, and cannot resolve this issue with that person, you may contact the North Carolina Board o Licensed Professional Counselors at (919) 661-0820, North Carolina Marriage And Family Therapy Licensure Board (336) 794-3891, or North Carolina Social Work Certification and Licensure Board (800) 550-7009 or (336) 625-1679 for clarification of your rights or to lodge a complaint.

Authorization for Insurance & Consent for Services

I, the undersigned, have insurance coverage with _____ and assign directly to TherapyWorks Counseling all medical benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance company. I hereby authorize TherapyWorks Counseling to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I hereby give my consent for treatment for myself and/or my child for services to be provided by TherapyWorks Counseling. I understand that I may discontinue at any time. I have read the TherapyWorks Counseling Information sheet and certify that the above information is correct.

Cancellation/No Show Policy

I understand cancellations must be made 24 hours in advance. I will be charged $50.00 in the event I do not give a timely cancellation notice or do not show for my appointment.
I understand that I am responsible for this charge and that insurance will not pay for cancellations or no shows.

Signature of Insured/Guardian/Responsible Party: _____ Date: _____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____

Name: _____ **Date of Birth:** _____ **SS#:** _____ **Intake Date:** _____

TherapyWorks Counseling, PLLC

ADULT INTAKE FORM

Notice Regarding Our Privacy Statement

This notice describes how healthcare information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
Our commitment here at TherapyWorks Counseling is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.
During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances in which information may be shared.

- For payment purposes, we may use the services of a billing service.
- It may be necessary for your provider to consult with other providers for the best care.
- Your family may need to be involved in your care.
- Your attorney, EAP, or Workman's Comp entity may need information concerning your care.

If you have any questions about your privacy at our practice, please contact Jack L. Hileman, LMFT, Privacy Officer and Executive Director. If you believe your rights have been violated or have a complaint about our practice, you may contact Jack L. Hileman, or the Secretary, Department of Health and Human Services.

By signing this document I have read and understood *TherapyWorks Counseling Privacy Practices.*

Signature of Client: _____ Date: _____

Person Providing Notice: _____ Date: _____

Name: _____ **Date of Birth:** _____ **SS#:** _____ **Intake Date:** _____

TherapyWorks Counseling, PLLC

ADULT INTAKE FORM

Financial Agreement

Thank you for choosing TherapyWorks Counseling! We consider it a privilege to serve your needs. The staff at TherapyWorks Counseling is committed to providing you with the highest level of care, and to building a successful relationship with you. We believe that an understanding of your financial responsibility is vital to that relationship, and our goal is not only to inform you of those responsibilities, but to keep open lines of communication regarding them. If at any time you have questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact your therapist.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued clients.

Please understand that payment for services is an important part of therapeutic relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service.

A $35.00 service fee will be charged for all returned checks.

Insurance

Please remember that your insurance policy is a contract between *you and your insurance carrier*. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that clients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect clients to be interactive and responsible for communicating with their insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information, and to notify our office of any insurance changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo ID when accepting insurance information. We will inform you if we ate participating in your current insurance plan, but if you change insurance at any time, it is YOUR responsibility to let us know. Failure to provide all required information may necessitate client payment of all charges.

When insurance is filed we *are LEGALLY BOUND to collect copayments, co-insurance and deductibles, as outlined by your insurance carrier.* We cannot discount or waive co-payments, deductibles, or other insurance-related fees for service. If you do not want to file with your insurance carrier, and we are providers for that carrier, we still need to know you have a policy so we can adjust our fees according to our contract with the insurance company. Please be aware that out-of network insurance carriers often prohibit assignment of benefits, and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges, and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. If, however, it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for schoo1, sports, extra- curricular appointments, or disability claims, there will be an administrative fee of $35.00.

Missed Appointments

We require 24 hours advance notice of cancelled appointments. This allows us to offer the appointment to another client. **If you fail to keep your appointments without notifying us in advance, a $50.00 missed appointment fee will be applied to your bill.** Repeated missed appointments without notification may cause you to be discharged from the practice, so that we can provide care to other clients.

Medical Records Fees and Release of Medical Records

Clients are entitled, under federal law to have access to their protected health information, and we follow all rules, guidelines, and exceptions to ensure compliance to client rights. Providers also have the right to compensation for records, and our fees are a reasonable and cost-based for copies including the copying, supplies, labor and postage of the files and/or summaries.

To release medical records to another provider; release of information must be signed at this practice or the practice to which you are transferring. Due to their sensitivity, the release of medical records to client/parent must be accomplished during a **scheduled appointment** with MD, counselor, or Nurse Practitioner who will go over medical records before releasing. All records are confidential. **Copies of medical records require $35.00.** We prefer not to release records to individuals, because your records include sensitive information which could be used to harm you or in identity theft. If you are moving, or going to another practice, please let us know the name, address, and fax number of the new practice, and we will provide the records directly to them.

I have read and understand the above financial policy. I agree *to assign insurance benefits to TherapyWorks Counseling whenever applicable. I also agree, in addition to the amount owed, that 1 will be responsible for the fee charged by the collection agency for costs of collections, if such action becomes necessary.*

Signature of Insured or Authorized Representative: _____ Date: _____

Name: _____ **Date of Birth:** _____ **SS#:** _____ **Intake Date:** _____

TherapyWorks Counseling, PLLC

ADULT INTAKE FORM

Information Sheet

This sheet is for you to keep.

Office Hours are by appointment. You can reach a clinician at 336-202-0846.

Fees for Therapist Services:
The fee for Diagnostic Evaluation is $140.00. The fee for therapy is $130.00 per 50-minute session.

Insurance Services:
In most cases your health insurance may provide payment for part of your therapy. It is your responsibility to verify your coverage and **obtain authorization** from your insurance carrier. Payment of co-pays/deductibles is required at each session. Please notify your therapist of **any change in your insurance, address, and telephone number.** We participate with most insurance carriers. Fees are subject to change. If you do not provide proper insurance/authorization at time of service you are responsible for the bill. We are legally obligated to collect all co-pays and deductibles.

Payment Information:
We CASH & CHECK for payments and co-payments at this time. Any checks returned due to insufficient funds (NSF) will result in an additional charge of $25.00. The amount of the check, $35.00 service charge, and any unpaid balance of the account must be paid in cash prior to scheduling the next session.
Payment is expected at time of service. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Cancellation Policy:
CANCELAATIONS REQUIRE A 24 HOUR NOTICE IN ADVANCE. You will be charged $50.00 if cancellations are not received more than 24 hours prior to your appointment. **Insurance does not pay for "NO SHOWS". Continuous cancellation/no shows could result in pre-payment before scheduling appointments or dismissal from practice. You are responsible for no shows and late appointment cancellations at next appointment. Please phone your therapist to cancel appointment.**

Name: _____ **Date of Birth:** _____ **SS#:** _____ **Intake Date:** _____

Diversity Questions

We at TWC celebrate diversity and want to be sensitive to all needs of our clients. We are providing this form to not only understand our client's needs better, but to start an ongoing conversation about how we can best meet your needs. Please take a brief moment to answer the following questions.

1. Have you ever experienced discrimination because of the following (select all that apply):

   - ☐ Race
   - ☐ Religion
   - ☐ Gender
   - ☐ Sexual Orientation
   - ☐ Age
   - ☐ Mental Health
   - ☐ Appearance
   - ☐ Social Status

   If yes, please provide a brief explanation.

2. Are there important personal cultural aspects about yourself that you would like your therapist to know about? ☐ No ☐ Yes

   If yes, please explain.

3. We are all a mix of many identities. What identities do you believe have had the biggest impact in your life?

4. If there are issues of race, culture, spirituality, or identity that come up in session, what do you need from your therapist in order to feel comfortable talking about these issues?