



Welcome!

Thank you for choosing Counseling for Life for your therapeutic needs!

Below is important information to review as you start your counseling journey. Please reach out to office staff or your counselor if you have any questions. We look forward to working together!

Please review the following office policies:

1. Please come into the waiting room and check in at the front desk, taking care of any insurance questions or balances prior to your session. If the front door is locked and it is after your appointment time, please call 864-353-3384 and leave a message. This will notify your clinician and they will be right out to greet you.
2. **Appointment Attendance:** Your appointment time is set specifically for you, so please notify the office **24 business hours** in advance if you need to cancel or reschedule. There will be a **one hundred dollar (\$100)** missed appointment/last minute cancellation fee charged for all appointments in which 24 business hours' notice was not provided, the exception being symptoms of illness or lice. After two missed appointments or last minute cancellations, no further appointments will be scheduled.
3. The patient is responsible for all deductible, copay, and coinsurance amounts at the time the service is rendered. Any and all fees not paid by insurance within 90 days are the responsibility of the patient or caregiver. If your copay is unknown at the time of the initial appointment, there is a \$50 copay charged to the card on file. If you choose to not leave a card on file, the intial copay will be \$100. Appointments will be suspended until outstanding balances in excess of \$100 are paid in full.
4. Please do not pick up any animals at the farm without your therapist present or let them out of their enclosures. Our animals are friendly but everything with a beak or teeth will use them if they think you look tasty!
5. Any patients under the age of 15 must have a parent or guardian check them in and out at each appointment. No minors under the age of 15 are permitted to stay in the waiting room unattended.
6. The on-call clinician contact number for emergencies will be on the recorded message at 864-353-3384.

I have read and agree to the above office policies of Counseling for Life.

Name of patients: _____ Date: _____

Signature of patient: _____

Signature of patient: _____



Patient Information Form

Date: _____

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City, State, Zip: _____

Preferred Phone Number: _____ Email: _____

Alternate Phone Number: _____

Age: _____ Gender: male female other

Relationship Status: single married divorced domestic partner other

Referral Source: _____ Family Physician: _____

Employment Status: full-time part-time retired unemployed student

Employer Name: _____

City, State of Employer: _____ Work Phone: _____

Emergency Contact _____ Relationship to Patient: _____

Phone: _____

For Children:

Parent/Caregiver #1: _____ Phone #: _____

Parent/Caregiver #2: _____ Phone #: _____

School: _____ Grade: _____

Please check one:

- Self-Pay
- INSURANCE

Subscriber Name: _____

Subscriber Address: _____

City, State, Zip: _____

Subscriber Date of Birth: _____ Soc Sec #: _____

Relationship to patient: _____ Employer of Subscriber: _____

Name of Insurance: _____

ID# _____ Group #: _____



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FAX PRIVACY WAIVER

I, _____, date of birth _____, understand that my records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve Counseling for Life, Inc., of all liability.

_____ **(Please initial)** I give my consent to fax my records for the purposes of treatment, payment, or other healthcare needs and understand that I may withdraw this consent at any time in writing.

TECHNOLOGY WAIVER

_____ **(Please initial)** I give my consent to receive text messages and emails from Counseling for Life, Inc. I understand that these are not secure communications and by signing below, I absolve Counseling for Life, Inc., of all liability.

Patient, Parent, or Legal Caretaker Signature

Date

Printed Name

Witness Signature

Date



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Date

Printed Name

Witness Signature

Date



Authorization to Disclose Health Care Information

Patient name: _____ Date of birth: _____

Please release health care information to:

Name and Organization: _____

Address: _____

City, State: _____ Zip Code: _____ Phone: _____

By signing this Authorization, I authorize Counseling for Life, Inc. to disclose the following health information:

All Health Information about me, including my clinical records, created or received by Counseling for Life, Inc.

This information may include, if applicable:

Information about mental health diagnosis or treatment including psychotherapy notes.

Information about diagnosis or treatment for alcohol or drug abuse.

Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

Information about diagnosis or treatment of Sexually Transmitted Disease(s).

All Health Information about me as described in the preceding checkbox, excluding the following:

Specific Health Information including only:

This release is reciprocal _____ (initials)

For the Purpose(s) of: _____

This authorization ends: (check only one box)

in one (1) year
when the following occurs: _____

Other Important Information

You may refuse to sign or cancel this Authorization at any time, in writing, as allowed by law. This will not affect any actions already taken by the above named clinicians and Counseling for Life, Inc. in reliance upon your original request.

There are three ways to cancel this Authorization:

- 1) Sign and date a revocation form. This form is available from Counseling for Life; or
- 2) Submit a signed, dated letter to Counseling for Life, Inc. to cancel the authorization; or
- 3) Write "CANCEL" on this original form with your signature and the date.

Your cancellation or refusal to sign this Authorization will not affect the commencement, continuation, or quality of your treatment. Once your information is released, Counseling for Life, Inc. has relinquished control of it, and the recipient may re-disclose it and privacy laws may no longer protect it. By signing below you are indicating that you understand all the above stipulations and that you hereby release Counseling for Life, Inc. from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

Signature of Patient or legally authorized representative

Date

Time

Witness Signature

Date

Time



Authorization to Disclose Health Care Information

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Signature of Patient or legally authorized representative

Date

Time

Witness Signature

Date

Time



Patient Credit/Debit Card Form

All patients are required to keep a valid credit or debit card on file.

For your convenience, this card will be used after services are rendered unless you choose to pay with check or cash at the time of your appointment. This card will also be used for tele-health appointments, outstanding balances, no-show fees or cancellations with less than 24 business hours' notice (illness and extenuating circumstances being the exceptions).

All credit card information will be kept confidential and in a secure location.

Credit/Debit Card Type:

MasterCard

VISA

Discover

AmEX

Name on Card:

Card Number:

Expiration:

CVV Code:

Zip Code:

Email address for receipt:

"I, _____ (print name) have read and understand the terms of providing my credit/debit card information to Counseling for Life, Inc. **I understand that my card will be charged unless I pay with cash or check at the end of each session**, for telehealth sessions, for no-show or late cancellations (\$100), or for outstanding balances. Any questions I have about this agreement have been answered and I authorize this card to be charged for the reasons outlined above."

Patient Signature (or caregiver on behalf of minor)

Date