COUNSELING FOR LIFE

ADULTS • ADOLESCENTS • CHILDREN

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 notifiy 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. 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.

5. 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:_____

1209 N Fant St * Anderson, SC 29621 * PHONE 864-353-3384 * FAX 864-222-9715

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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:

- o Self-Pay
- o 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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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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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

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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

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