CHICAGO CHRISTIAN COUNSELING CENTER

NEW CLIENT PACKET

Thank you for choosing Chicago Christian Counseling Center (CCCC) as your provider for your mental health care.

The documents in this New Client Packet are explained below. Please GIVE THIS NEW CLIENT PACKET TO YOUR THERAPIST AT YOUR 1ST APPOINTMENT after you have read and signed all the appropriate documents in it.

NOTE: If you are typing your information into this form, please note that all signatures must be handwritten.

This New Client Packet includes the following documents:

Client Information Form: Please complete this in its entirety so we will have all the necessary information to assist with your insurance billing. We also request that we be able to make a copy of your insurance card.

Insurance Authorization and Assignment of Benefits, Confidentiality and Authorization for Treatment, Acknowledgement of Receipt of Notice of Privacy Practices: This form gives permission for filing with your insurance and treatment. This form also indicates that your therapist has provided a copy of our Notice of Privacy Practices (HIPAA). Both you and your therapist will sign this form. A copy of our Notice of Privacy Practices will be given to you by your therapist.

Office & Fee Policies: This form explains the office and fee policies of CCCC. Please provide the signature of the Responsible Party at the bottom of the form. A copy of our Office and Fee Policies will be given to you by your therapist.

Granting Permission Regarding Billing and/or Scheduling and Email/Text Authorization: This form gives Chicago Christian Counseling Center permission to speak to authorized parties regarding the client's billing and/or scheduling information. This form also allows for email and/or texting appointment reminders with client permission. Please sign and indicate which permissions are granted to our staff.

Request to Release Information to Primary Care Physician (PCP): This form indicates your wishes in regards to releasing treatment information to your PCP. If you check the box requesting a release of information, we are required to exchange information with your PCP regarding your treatment. If you do not want us to exchange information with your PCP, please check the appropriate box and sign the bottom portion. If you do not have a PCP, please check that box and sign at the bottom.

Symptom Checklists: This provides your therapist with some information regarding why you are here today. Two checklists are provided. The first form is for the client. The second checklist is for the parent/guardian or significant other/spouse.

Client Information Form

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(Please Print)

Client First Name _____ Last Name _____ Date _____

Address _____ Apt. #_____ City _____ State ____ Zip _____

Phone ☐H ☐W ☐C _____ Phone ☐H ☐W ☐C _____

Social Security # _____ DOB _____ Age _____ Sex ☐M ☐F

Marital Status: ☐S ☐M ☐Sep ☐D ☐W

Church Affiliation (if any) _____ Denomination _____

If client is a minor, is there a joint custody agreement issued by the court? ☐YES ☐NO
If yes, please see Parental/Guardian Consent Forms.

Please Check: ☐ Parent/Guardian ☐ Significant Other/Spouse Information

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Phone ☐H ☐W ☐C _____ Phone ☐H ☐W ☐C _____

Social Security # _____ DOB _____ Age _____ Sex ☐M ☐F

Emergency Information

Emergency Contact Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Alternate Phone_____

Insurance Information

PRIMARY Insured _____ DOB _____ SS # _____

Relationship to Client: _____ Employer _____

Primary Insurance Carrier _____ Phone _____

ID# _____ Group # _____

SECONDARY Insured _____ DOB _____ SS # _____

Relationship to Client: _____ Employer _____

Secondary Insurance Carrier _____ Phone _____

ID# _____ Group # _____

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Insurance Authorization and Assignment of Benefits

I hereby authorize the Chicago Christian Counseling Center to (A) furnish the information concerning the client's diagnosis and treatments to the client's insurance carrier(s) and (B) request the client's insurance carrier(s) to direct payment to the Chicago Christian Counseling Center.

Client/Authorized Person's Signature: _____ Date _____

Confidentiality and Authorization for Treatment

All information regarding clients is considered strictly confidential and will not be given to anyone outside of Chicago Christian Counseling Center without your written consent. Exceptions are listed in our Notice of Privacy Practices. In the event of a request for the transfer of records to another party, the records will be forwarded directly to that party only upon receipt of your written request.

I give my consent to (treating therapist) _____ to provide evaluation and treatment that we may mutually determine to be appropriate. I am participating in my treatment voluntarily and understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

_____ (Please initial if applicable) I understand that the above named therapist is receiving weekly supervision from a Chicago Christian Counseling Center licensed therapist.

Client (age 12 or over) Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, (please print client name)_____ have been presented with a copy of Chicago Christian Counseling Center's Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of the Notice.

Please check one:

☐ I have read and received a copy of the Notice of Privacy Practices.

☐ I decline receiving a copy of the Notice of Privacy Practices and am aware that this Notice can be viewed online at http://www.chicagochristiancounseling.org/files/notice_of_privacy_practices.pdf

Signature of Recipient (age 12 or over)_____ Date_____

Signature of Parent/Guardian_____ Date_____

Internal Use Only:

☐ I have provided my client with a copy of the Notice of Privacy Practices.

☐ My client has declined receiving a copy of the Notice of Privacy Practices.

Signature of Mental Health Provider _____ Date _____

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Office and Fee Policies

Thank you for choosing us as your counseling services provider. We are committed to helping you reach your goals. We ask that you commit yourself to the timely payment of your agreed upon portion of the charge. The following is a statement of our office and financial policies

Insurance Clients:
As a service to you, whenever your insurance will work with us, we will process your insurance claims. Benefits payable are determined at the point the claim is processed. Insurance quotes by our office staff are not a guarantee of benefits. If you have questions regarding your benefits, please call your insurance company directly. If insurance does not pay, all charges will be the responsibility of the client.

Copayments are due at the time of service.

It is the client's responsibility to notify our Billing Office within a timely matter if your insurance carrier changes.

NSF Checks
There will be a $15.00 charge for any returned check.

Cancellation/No Show Policy
It is the responsibility of the client to notify the office 24 hours in advance when cancelling an appointment. If 24 hours is not given, a $50.00 late cancellation/no show fee will be charged. This fee is not covered by insurance, and will be billed directly to the client.

Telephone Calls
Telephone calls lasting more than 5 minutes will be billed to the client. Clients will be billed $1.00 for each additional minute for the duration of the telephone call.

Completion of Forms/Letters
Completion of Forms will be billed at $25.00 up to 2 pages. Additional pages will be billed at $10.00 per page. Request for letters will be billed at $25.00.

This fee is not covered by insurance, and will be billed directly to the client. Please allow up to 10 business days for the completion of requested letters/forms.

Record Requests
In order to fulfill a records request, a signed Release of Information (ROI) form must be completed and submitted to our office. A fee of $25.00 will be applied to all Record Requests. Please allow 2 – 4 weeks* from the receipt of the ROI for the request to be completed. (*up to 30 days)

Financial Responsibility
Account balances that remain unpaid for more than 90 days may be forwarded to a collection agency. The client will bear the full cost of collection activity.

We accept cash, checks, VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER.

I have read and I understand the above policies and agree to abide by them.

Financially Responsible Party _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

Phone ☐H ☐W ☐C _____ Alternate Phone ☐H ☐W ☐C _____

SS # _____ DOB _____

Signature _____ Date _____

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Granting Permission Regarding Billing and/or Scheduling

From time to time you may want/need someone, on your behalf, to contact a member of our staff about your billing and/or your appointments. Please indicate the name(s) of those individuals authorized by you to speak to our staff.

Name _____ Relationship _____ ☐ Billing Only ☐ Scheduling Only ☐ BOTH

Name _____ Relationship _____ ☐ Billing Only ☐ Scheduling Only ☐ BOTH

OR

☐ I do not want to grant permission to other people to discuss Billing and/or Scheduling with your staff on my behalf.

Client (age 12 or over) Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Email/Text Authorization

I understand that email and text reminders are a courtesy and it is ultimately my responsibility as a client to remember my appointments.

☐ I hereby give Chicago Christian Counseling Center permission to send email reminders regarding my appointment dates and times. I understand that email is not a confidential mode of communication.

☐ I do not want to receive appointment reminders through email.

1. Email Address _____

2. Email Address _____

I would also like to receive CCCC e|Newsletter (emailed articles by therapists 6x year) ☐Yes ☐No

AND/OR

☐ I hereby give Chicago Christian Counseling Center permission to send text reminders regarding my appointment dates and times. I understand that texting is not a confidential mode of communication.

☐ I do not want to receive appointment reminders through text.

Cell Number (only one) _____

Client (age 12 or over) Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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Request to Release Information to Primary Care Physician (PCP)

Communication between your therapist and your PCP can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. Please indicate your wishes below. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent shall expire one (1) year from the date of signature, unless another date is specified.

PLEASE PRINT

_____

Patient Name

Please Check One:

☐ I do not have a Primary Care Physician.

☐ I do not authorize CCCC to release information to my Primary Care Physician.

☐ I request that CCCC release mental health/substance abuse information to my Primary Care Physician.

Complete information must be provided to contact your PCP:

Primary Care Physician Name:_____

Phone:_____

Note: Please sign below regardless of which box you checked above.

Client (age 12 or over) Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

*If you are signing as a Personal Representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

For Internal Use Only:

Fax Verified By _____ Date _____ Fax Number _____

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SYMPTOM CHECKLIST A

(to be filled out by Client)

Date_____

*(Please Print) Client Last Name*_____*First Name*_____

Statement of problem(s) for which you now seek counseling:

Please rate the degree to which you have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	Never	Sometimes	Often
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along w/others			
Violence			
Health problems			
Legal problems			
Financial problems			

When did the symptoms first begin?____/____/____ (date)

Have you ever been treated for these symptoms before?_____Yes _____No

If yes, when? ____/____/____(date)

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SYMPTOM CHECKLIST B

(to be filled out by Parent/Guardian if client is minor or by Significant Other/Spouse if couple)

Date_____

*(Please Print) Client Last Name*_____*First Name*_____

Statement of problem(s) for which you/your child now seek counseling:

Please rate the degree to which you/your child have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	**Never**	**Sometimes**	**Often**
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along w/others			
Violence			
Health problems			
Legal problems			
Financial problems			

When did the symptoms first begin?____/____/____ (date)

Have you ever been treated for these symptoms before?_____Yes _____No

If yes, when? ____/____/____(date)