PATIENT INFORMATION

DATE_____

PATIENT NAME _____ DATE OF BIRTH_____

STREET_____ CITY_____ ST_____ ZIP_____

SEX_____ MARITAL STATUS_____ SS#_____ EMPLOYER_____

HOME PHONE_____ WORK PHONE_____ CELL_____

EMAIL_____ REFERRED BY_____

FINANCIAL RESPONSIBILITY

NAME_____ RELATIONSHIP TO PATIENT_____

STREET_____ CITY_____ ST_____ ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL_____

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

INSURED'S D.O.B._____ EMPLOYER_____ PHONE_____

NAME OF INSURANCE CARRIER_____ PHONE_____

ADDRESS_____ CITY_____ ST_____ ZIP_____

SS# OF INSURED_____ POLICY ID#_____ GROUP #_____

IF SECONDARY INSURANCE IS AVAILABLE, PLEASE COMPLETEBELOW

NAME OF INSURED_____ RELATIONSHIP TOPATIENT_____

INSURED'S D.O.B._____ EMPLOYER_____ PHONE_____

NAME OF INSURANCE CARRIER_____ PHONE_____

ADDRESS_____ CITY_____ ST_____ ZIP_____

SS# OF INSURED_____ POLICY ID#_____ GROUP #_____

RELEASE OF INFORMATION

I authorize the release of any medical or other information necesary to process this claim

Signature of patient or parent/guardian_____ Date_____

I authorize payment of medical benefits directly to the provider:

Signature of patient orparent/guardian_____ Date_____

FOR OFFICE USE ONLY

THERAPIST:_____ DIAGNOSIS CODE 1:_____ 2:_____

F · A · C · T · S

COUNSELING

Family And Child Therapy Services

Solutions for living

COUNSELING AND PAYMENT AGREEMENT

1. The cost of counseling services is $ 130.00 per hour for individual/family/group counseling.

2. The policy of this office is for payment at the time services are rendered. If you are unable to do this, please discuss alternative arrangements with your counselor in advance.

3. We require at least 24 hours advance notice for cancelled appointments. If this office is not notified of a cancellation 24 hours in advance, YOU MAY BE CHARGED FOR THE MISSED SESSION.

4. There may be a charge assessed but not limited to attendance at meetings on your behalf, telephone calls or correspondence. These charges will be assessed at the discretion of the counselor and you will be notified in writing of any charges, before the additional service is rendered.

5. Client records are confidential. However, there are some circumstances when a therapist is legally required to provide information. These are: if a client is in danger of harming him/herself or others, if there is suspected child abuse, if a court orders a release of a treatment record, and when treatment information is requested by a client's insurance carrier, and when a waiver is signed with the insurance company giving the insurance carrier right to treatment information.

6. In order to release the records of your counseling, we require a written release(or see above #5). NO RECORDS will be released until all sums due this office are paid.

7. Counseling may be terminated by you, the client, by informing this office of your desire to discontinue counseling.

8. Counseling may be terminated by the counselor, at the counselor's discretion. You will be notified if counseling is to be ended and an appropriate referral will be made for continuation of therapy, if indicated.

9. If you have any questions this agreement, please ask your counselor.

I acknowledge that I have read this agreement fully, understand the terms, and agree to abide by these terms and guidelines.

_____ _____

CLIENT DATE

_____ _____

FACTS Counseling DATE

2105 West Genesee Street, Suite 113 • Syracuse, New York 13219 • (315) 488-1884