17224 VanWagoner Road
Spring Lake, MI 49456

1388 Baldwin Street, Suite A
Jenison, MI 49428

4040 W 72nd Street
Fremont, MI 49412

1465 3 Mile Rd NW
Grand Rapids, MI 49544

Phone: 616-296-2130 cccoffice@cccounseling.net Fax: 616-296-2148

Today's Date: _____

Client Full Name: _____ Preferred Name:_____

DOB: _____

Home Address: _____ Age: _____ Sex: _____

_____ SS # _____-_____-_____

Marital Status: _____

Home Phone: _____ Preferred Appointment Reminders: Home___ Work___ Cell___ Text___ Email___

Work Phone: _____

Cell Phone: _____ Contact person if different than client:

_____

Email address _____

An adult client is considered responsible for his/her own account. The responsible party for a minor account (under age 18) rests with the parent seeking services. If client is a minor child, responsible adult seeking services:

_____	_____	_____	_____
Parent Name	Phone #	DOB	SS #

If someone other than the client will be financially responsible for this account, indicate here:

Other Responsible Party: _____ Phone : _____

Address: _____

_____

Emergency Contact Name: _____ Phone _____

Relationship to the Client: _____

Is there anyone else who can schedule appointments for you and we can release scheduling or billing information to?

Name:_____ ***Phone:***_____ ***Relationship:***_____

How did you find out or hear about our office? _____

Medications: _____

Other Mental Health Providers: _____

The above information is accurate and complete to the best of my knowledge:

_____ _____

Signature of Client / Parent / Legal Guardian Date

APPOINTMENT REMINDER/CONFIRMATION CALLS

- I request Compassionate Christian Counseling staff to make reminder contact with me prior to appointments.
- By signing here, I consent to receive reminder calls, text and/or emails as indicated on the previous page.
- I understand that the time and location of my appointment may be communicated to anyone answering my phone or left on my answering machine/ voice mail.
- I also understand that reminder calls are a courtesy and may occur if I am late or miss an appointment.

_____ _____

Signature of Client / Parent / Legal Guardian Date

PHONE INFORMATION

If there is a mental health emergency, please call 911 or go the nearest emergency room.
Should there be an **URGENT** need to speak with your therapist,

Call: 616-296-2130 during business hours
231-923-6728 if after business hours.

Our staff will work with you to reach your therapist if at all possible.

Please be advised there will be a regular session fee charged based on the minutes used and are often not billable to insurance.

I understand that there are **fees associated to phone calls with my therapist** and will be personally responsible for those charges.

_____ _____

Signature of Client / Parent / Legal Guardian Date

PUNCTUALITY AND ATTENDANCE

When you make an appointment, your mental health professional will reserve that time for you. It is your responsibility to keep the appointment and apply yourself wholeheartedly to benefit from each session. Frequent cancellations will also obstruct your progress in treatment and may result in the discontinuance of treatment.

If you are late, you will be still be charged for the full scheduled appointment. If you miss an appointment or cancel less than 24 hours in advance there is a service charge of 50% of the standard fee for the scheduled service which is **NOT insurance billable**. This is not a penalty, but rather your payment for the time reserved for you. It is your responsibility to contact the office and reschedule cancelled appointments.

I understand that a 24 hour notice must be given for all cancelled appointments to **avoid the $40 cancellation fee.**

_____ _____

Signature of Client / Parent / Legal Guardian Date

COST OF TREATMENT

- Please understand that payment of your bill is considered a part of your treatment.
- Our therapists are independent professionals who CCC provides billing services for.
- If you are using insurance, standard billing fees are charged to your insurance that are customary for our area.
- If you do not have insurance coverage or you have an insurance that we do not bill, we do require payment in full at the time of service based on your therapist's out-of-pocket fees. **NOTE:** Some therapists do offer a sliding scale for uninsured clients. Inquire with office staff or your therapists for this option.
- When utilizing a qualified insurance carrier, you will be required to pay all copays at the time of services.
- When deductibles are required, we will bill you after the insurance determination and require your payment in full within 30 days.
- The balance is your responsibility whether your insurance company pays or not.
- Your insurance policy is a contract between you and your insurance company. You should contact your carrier as to what your benefits are along with your copay and/or deductible that may be required.

I understand and agree to the cost of treatment:

_____ _____

Signature of client/parent/legal guardian Date

CONSENT FOR TREATMENT FORM:

I acknowledge that I am voluntarily consenting to mental health assessment and/or treatment services. I have the following rights in regards to services and may discuss these at any time with my mental health professional:

- I can discuss any intervention being suggested, as well as any questions I have concerning the course, purpose and direction of therapy.
- I have the option to explore any other possible treatments or alternatives to psychotherapy.
- I have the opportunity to discuss any possible risks, discomforts or side effects as well as any benefits that may occur in the course of psychotherapy.
- I have the right to withdraw from therapy at any time and realize it is preferable to discuss with my therapist first.
- My therapist will talk about the limitations of privileged communication and confidentiality. Any questions I have will be answered.
- I understand that there are no guarantees that can be promised regarding the outcome of psychotherapy. I will be informed of what outcomes are possible.
- I agree that in the event of an emergency, contact will be made to appropriate parties on my behalf to protect others or myself.

I have read and understand the above information and will be able to address any questions pertaining to these areas as therapy progresses. On this basis, I am authorizing the necessary psychotherapeutic services.

_____ _____

Signature of client/parent/legal guardian Date

CONSENT FOR TREATMENT OF MINORS (if this pertains to you)

I give permission to provide a mental health assessment and treatment services for my minor child: _____.

- I am aware that Compassionate Christian Counseling provides office space and support services for the mental health professionals associated with CCC.
- Under state law if a mental health professional knows or has a reason to believe that my child has been or is being physically abused, sexually abused or neglected, this information must be reported to Child Protective Services.
- All information concerning danger to a child will be reported.
- I also understand that the specific content of sessions between my child and his/her therapist will remain confidential and that my child has the right to request that information about his/her treatment not be shared with me.
- General reports of my child's progress may be provided to me under this agreement.

_____ _____

Signature of client/parent/legal guardian Date

RELEASE OF INFORMATION

I hereby authorize the exchange of clinical information between my insurance company, gatekeeper, primary care physician and any other specialists to whom I would be referred for treatment under my commercial insurance, HMO coverage or Employee Assistance Program. I authorize the release of information between my mental health specialist and any court ordered requests for information. I authorize that when my therapist is uncertain of how to address a particular problem they may seek advice from another therapist within our organization. I understand that at no time will my name be used in this discussion. I also authorize a quality-assurance review of my file contents by an appropriate member of the clinical staff.

_____ _____

Signature of client/parent/legal guardian Date

ACKNOWLEDGEMENT

- I understand that I am financially responsible for the cost of services and give permission for the release of financial information to a collection agency or small claims court in the event I fail to live up to this obligation. I further acknowledge that any costs for these financial services will be added to my bill
- Compassionate Christian Counseling is an office management entity only. It is not engaged in the practice of psychology, social work, or any other professional services.
- You are a client with an individual, independent provider working out of Compassionate Christian Counseling's office. No provider shall in any way be construed as a partner, shareholder, employee, associate or agent of any other provider in this office.
- In accordance with Michigan law, the process for filing a complaint against any licensed or registered health care professional may be found at http://www.michigan.gov/lara

_____ _____

Signature of client/parent/legal guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM
available in our office as well as our website cccounseling.net

I hereby acknowledge that on _____ I received the Notice of Privacy Practices from Compassionate Christian Counseling, which sets forth the ways in which my personal health information may be used or disclosed by Compassionate Christian Counseling's Clinicians and outlines my rights with respect to such information.

_____ _____

Signature of Client / Parent / Legal Guardian Date