Smithfield Christian Counseling-Sheila D. Robinette, LPC CLIENT INFORMATION:

Client's full Name:______________________________________ SSN:__________________________________

Mailing Address:____

City:____ State:__________________ Zip:___________________

Telephone: (______)_______________ Restrictions when calling:____

Email_________________________________(used to communicate with billing agent)

Date of Birth:_______________________ Cell or work phone: (______)______________________________

Sex: ___Female ___Male ___ Age ___Height ___Weight Student Status: ___Part t. ___Full t. ___Not a student

Employment Status: ___Part time ____Full Time ___Retired ___Unemployed

Marital Status: ___Single ___Married ___Divorced ___Legally separated ___Widowed

Employer or school name (if applicable)____

Primary care physician:_________________________________ PCP Phone:__________________________________

INSURANCE INFORMATION:

1. Chief complaint:____ Date symptoms appeared:_________________

2: Has patient been seen previously in therapy?____________ If yes, when?____________________________________

3. Who referred you to this office?____

4. Is treatment being covered by Workman's Comp?____

5. Is need for treatment due to ____on the job injury or ___automobile accident?

6. Date of injury or accident ___________Employer at time of injury:____

7. Primary insurance company:____

ID Number:___________________________________ Group #___________________________________

Insurance Phone number:__________________________ Claims Address:_______________________________

Patient's relation to insured: ___Self ___Spouse ___Child ___Other

Insured's full name (if not self)______________________________ Insured's date of birth:_________________

Insured's Address:____

Insured's Employer:____

8. Secondary Insurance Company____

ID #:_______________________________ Group Plan#:____________________________

Insurance Phone:____________________ Ins.Address:______________________________

Insured's date of birth:_________________ Insured's address:___________________________

9. Primary person responsible for payment:

Name:_______________________________ Phone:_______________________________

DOB:_______________________________ SS #:_________________________________

10. Secondary person responsible for payment (if applicable)

Name:_______________________________Phone:_______________________________

DOB:________________________________ SS #:_______________________________

<u>Please be aware that a $40.00 fee may be charged for missed appointments or for appointments canceled without a 24 hour notice</u>. This fee is not billable to your insurance carrier.

Payment is due at the time of service unless otherwise arranged.

AUTHORIZATION:

I hereby authorize Sheila Robinette to bill all insurances and assign any benefits paid to her. I hereby state that all information stated on this form is correct to the best of my knowledge. Additionally, Sheila Robinette is authorized to release information to my insurance company and her authorized billing agency, Goss Practice Solutions. I understand that I am responsible for all charges not covered by my insurance. Furthermore, should legal action or collection services become necessary, I agree to pay all legal attorney or collection fees.

Signature:_____________________________ Date:__________________________________

TRICARE section only

Referring MD name____________________________________

NPI Number____

Practice Name__________________________________ Practice Phone#_____________________

(Referring MD is required. Referral written by a Nurse Practitioner or PA is not acceptable.

Smithfield Christian Counseling

Guidelines for therapy:

Therapy involves a process where you and the therapist develop goals centered on the problem area that led you to seek counseling. Clients are expected to complete homework such as reading psycho educational literature, or logging self talk. A referral for a psychiatric evaluation will be suggested to ensure comprehensive care if indicated. Needs and strengths are also incorporated into the treatment plan. Treatment is time limited and solution focused. I am aware that individual, couples, and family therapy are treatment options. Target goals for discharge will be set.

Nature and limits of Confidentiality:

The nature of the relationship between a therapist and client is confidential. The exceptions to breach confidentiality include: disclosure of sexual abuse, intent to harm self of others, incapacity of self care, when diagnosis or specific information is requested by court order, insurance company, or during case staffing. Any other instances in which confidentiality is compromised will be discussed with client and/or guardian.

Consent for treatment:

I authorize Smithfield Christian Counseling, LLC to evaluate and administer such treatments as are considered necessary and upon which we mutually agree. I agree to the administration of emergency medical treatment, including transportation to the local hospital.
If possible, an emergency contact will be notified. Please contact (Name, and phone number) ______________________________, in case of emergency.

I certify that I agree to and understand the above consent and limits of confidentiality, along with the guidelines for therapy.

Client Name:________________________________Date of Birth:_______

Client/Guardian Signature:___________________________Date:________

Witness:____Date:________

Smithfield Christian Counseling

Consent for Information Disclosure

I authorize Smithfield Christian Counseling/Sheila D. Robinette, LPC at 341 Main Street, Smithfield, VA 23430 to exchange information with my **primary care physician** (write in the name of the person/agency along with address and phone number)____
____

For the purpose of: coordination of care

Information to be exchanged: Diagnosis, method of treatment recommended, and progress notes, if applicable. (Please mail information to the above address if sending more than five pages. Otherwise, fax information to (757) 356-1813.)

I understand that this release will expire upon discharge or written cancellation. I understand that my records are protected under federal and states confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in laws and regulations. I also understand that I may revoke this consent at any time.

________________________	______________________________	__________
Client Name (Please print)	Client Signature	Date
________________________	______________________________	__________
Client's social security number	Legal Guardian's signature	Date
________________________	______________________________	__________
Client's date of birth	Witness Signature	Date

Smithfield Christian Counseling

Consent for Information Disclosure

I authorize Smithfield Christian Counseling/Sheila D. Robinette, LPC at 341 Main Street, Smithfield, VA 23430 to exchange information with my **mental health provider** (write in the name of the person/agency along with address and phone number)____
____

For the purpose of: coordination of care

Information to be exchanged: Diagnosis, method of treatment recommended, and progress notes, if applicable. (Please mail information to the above address if sending more than five pages. Otherwise, fax information to (757) 356-1813.)

I understand that this release will expire upon discharge or written cancellation. I understand that my records are protected under federal and states confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in laws and regulations. I also understand that I may revoke this consent at any time.

______________________	____________________________	__________
Client Name (Please print)	Client Signature	Date
______________________	____________________________	__________
Client's social security number	Legal Guardian's signature	Date
______________________	____________________________	__________
Client's date of birth	Witness Signature	Date

Patient Consent Form ***Provider: S. Robinette***

As your treating health care provider, it is my duty to inform you of your rights and my policies regarding treatment.

As your treating provider, I will make every effort to release the minimum information required for treatment and payment of services. Information about your treatment and diagnosis must be provided to your insurance company to receive payment for services. There are occasions when an insurance company may request my notes regarding your treatment before a claim will be considered. You may choose not to release this information and pay out-of-pocket. If you prefer that notes regarding our sessions NOT be released to your insurance carrier, please initial here ___________.

Information will not be released to any outside party without your prior consent in writing.

My office will take every precaution to protect all records and files containing identifiable information about you and your treatment. In addition, your treatment and session events will not be discussed with any unauthorized outside party.

As a patient, you have every right to question your treatment and any issues you may not understand or agree with.

Below is a guideline to procedures, should you have questions, please discuss them before your treatment begins.

The patient data form you complete today, your insurance information, if applicable, and your diagnosis, will be released to my authorized Billing Agency, ABS. Advantage Billing Solutions is governed under the same rules of privacy, and will provide the minimum information to your insurance company in order to secure payment for services.

Upon discontinuance of treatment, any balance owed will be billed through ABS. If this balance is carried over 90 days without effort to pay, it may be turned over to a collection agency. This will require release of your name, address, SSN, phone number, and amount owed to the collection agency.

Your signature is required below. By signing, you are stating that you understand the information contained and agree with the release policies. If at any time you wish to revoke your consent, you must submit this request in writing.

_______________________________________ ______________________

Print Patient Name Today's date

____

Patient or Authorized Guardian Signature (Include relationship to patient if not self.)

_____________________________________ ___________________________

Witness Name Witness Signature