Broken Chains Christian Counseling, Inc.

PERSONAL INFORMATION FORM

PRIMARY PERSON RECEIVING COUNSELING: _____

The name you'd like to go by: _____

ADDRESS: _____ City_____ ZIP _____

D.O.B: _____ SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____ CELL PHONE #: _____

HOME PHONE #: _____ WORK PHONE #:_____

I GIVE PERMISSION FOR BCCC TO SEND REMINDER CALLS BY WAY OF: (PLEASE CIRCLE)
TEXT or EMAIL

EMERGENCY CONTACT: (name, phone & relationship) _____

_____

MARITAL STATUS:
Never Married: / Divorced Since:_____ / Widowed Since: _____ / Married Since: _____

Other:_____

EMPLOYER: _____ Occupation: _____

Spouse/Partner's Name: _____Occupation: _____

RELIGIOUS AFFILIATION:_____ Currently active? _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE PLAN: _____

Policy Holder's Name: _____

Policy Holder's D.O.B: _____ Policy Holder's Social Security #: _____

Health Plan ID: _____ Group ID _____

My signature is in agreement that all the above information is correct and if insurance info. Is given, my signature gives Broken Chains Christian Counseling Inc. (BCCC) permission to use all information needed to bill my insurance.

Signature:_____ Date:_____

BROKEN CHAINS

CHRISTIAN COUNSELING Inc.

13000 N. 103rd. Ave. Suite 79

Sun City, Az. 85351

Office (623) 533-5138

Fax (623) 533-4271

FINANCIAL POLICY

First Name _____ Middle Initial _____ Last Name _____

Thank you for choosing **BROKEN CHAINS CHRISTIAN COUNSELING (B.C.C.C.):** as your health care provider. Please carefully read each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager will be glad to discuss these policies with you.

1) I understand that if I do not have my insurance card, referral, and or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

Initials: _____

2) I understand that **B.C.C.C.** will collect all co-pays at the time of visit and any deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and **B.C.C.C.**

Any over-payment to your account will be refunded to you at your request after payment and / or remittance has been received from your insurance company

Initials: _____

3) I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

Initials: _____

4) I understand that if I am unable to make a scheduled appointment, I need to contact **B.C.C.C.** at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from

scheduling appropriately and keep others in need of counseling from being seen. After the second missed appointment. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE

Initials: _____

5) I understand that if my account is not paid full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance. No additional appointments will be made until they are brought current.

initials: _____

6) **B.C.C.C.** will allow 60 days from the date of filing for my Insurance company to process or pay a claim. State law allows Insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my Insurance company with requested information needed to process a claim for services. It is also my responsibility to notify **B.C.C.C.** If there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

INITIALS: _____

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the counselor.

_____

Signature of Responsible Party Date

_____

Printed name of responsible party Relationship to Patient

Broken Chains Christian Counseling Inc. (BCCC)

FINANCIAL POLICY

All payments including copays and deductibles are due prior, or at the time of session. BCCC will file your insurance claims. However, if any information was given in error this may cause your claim to not be paid. BCCC will then look for corrective information to assure payment. If after 30 days, claims continue to be denied, then counseling services will be interrupted until billed balances are paid in full.

Below are the rates for PRIVATE PAY clients for 45-60 minute hour sessions an rates for SERVICES NOT COVERED by most insurances:

Initial Intakes

(Doctorate Level) ie; PhD, Psy D	$200.
(Licensed Master's Level) ie; LCSW, LPC, LMFT	$170.
(Associate Master's Level-Needing Supervision) ie; LAC, LMSW, LAMFT	$130.

Follow Up Sessions

(Doctorate Level) ie; PhD, Psy D	$170.
(Licensed Master's Level) ie; LCSW, LPC, LMFT	$150.
(Associate Master's Level-Needing Supervision) ie; LAC, LMSW, LAMFT	$100.

Tele Communications/Video Counseling (1 Hr)

(Doctorate Level) ie; PhD, Psy D	$225.
(Licensed Master's Level) ie; LCSW, LPC, LMFT	$175.
(Associate Master's Level-Needing Supervision) ie; LAC LMSW, LAMFT	$125.

Tele Communications/Video Counseling (30 Minutes)

(Doctorate Level) ie; Ph D, Psy D	$125.
(Licensed Masters Level) ie; LCSW, LPC, LMFT	$100.
(Associate Master's Level-Needing Supervision) ie; LAC LMSW, LAMFT	$70.

(There is no charge for brief telephonic phone conversations with your Therapist under 5 minutes)

Photocopies of Medical Records (Administration Fee)	$10.
Return Check Fee	$25.

Financial Policy Continued

Late Cancel / No Show Policy for Counseling Appointments:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another client from getting much needed treatment.

If any appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50.) fee; this will not be covered by our insurance company.

**Exceptions may be decided at the discretion of our provider.*

COURT APPEARANCES

***IN PERSON COURT APPEARANCES** regardless of time spent at court will be charged $900.

***TELEPHONIC COURT APPEARANCES** regardless of the time on phone will be charged $450.

*This includes review of records and travel time if applicable. Payment is due in full one week prior to court to give BCCC ample time to cancel and reschedule appointments.

DISABILITY PAPERWORK is done at the time of the session at No charge. Otherwise, a one hour self pay fee will be charged at $90 payable prior to being faxed.

I have read and understand this policy and will honor guidelines of this policy.

_____

Signature Date

Broken Chains Christian Counseling, Inc. (BCCC)

CONFIDENTIALITY AGREEMENT

The law protects the confidentiality of communication between clients and mental health professionals. Information can normally only be released about you to others with our written permission, though there are some exceptions you should be aware of:

- When there is suspected abuse of a child, elderly person, or disabled person.
- When it is your Therapist's professional opinion that you are in danger of harming yourself, another person, or are unable to care for yourself.
- If you report to your Therapist that you have intentions of physically hurting someone, your Therapist is required to inform that person of your intentions and notify the proper authorities.
- When the information is required by your insurance carrier for BCCC to be reimbursed for services provided or for quality management services.
- Your Therapist may disclose your information to other BCCC licensed Therapists for supervision, consultation, or to coordinate services if you or your family members are seeing Therapists in this office.

PATIENT BILL OF RIGHTS

- Receive high-quality service.
- Be Treated with respect and courtesy
- Have your information kept private and confidential except as described in B.C.C.C.'s privacy statement
- Be listened to and have staff work with you to address your concerns and needs
- Receive service in offices that are safe, clean and accessible
- Get information and support to help you make decisions to improve your situation
- Be served without discrimination
- Discuss with staff any questions or complaints that you may have
- Request a change of counselor's if there is another counselor available who can address your issues

This is what we ask from you

Treat the staff and others at Broken Chains Christian Counseling INC. with courtesy and respect

Let Broken Chains Christian Counseling know 24 hours before if you cannot come to an appointment

INFORMED CONSENT

I, the undersigned voluntarily consent to participate in psychotherapeutic counseling services provided by BCCC. I understand that I may withdraw from therapy at any time. I have received a copy of my rights.

With my signature I agree with all the above:

Signature of client or legal guardian _____

Please print Name _____

Date _____

Broken Chains Christian Counseling inc.

Legal History

Are You a United States Citizen ? ___ Yes ___ NO
Have you ever been arrested or been involved as a victim of a legal dispute for any reason ___ Yes ___ No
Drug related, for any reason ___ Yes ___ No Is counseling mandatory due to legal issues ___ Yes ____ No
If yes Please give dates and explanation:

DUI ? _____
Domestic Violence
Perpretator _____

_____

Domestic Violence
Victim _____

_____

Indecent exposure _____

Child custody dispute _____

_____

Fraud, Felony, or
Misdemeanor, other than driving _____

Sexual crimes _____

_____

Have you ever been imprisoned, incarcerated, or confined for any reason ? ___ Yes ___ No
If yes please give dates and explanation

_____

_____

_____

Have you ever been petitioned against your will because you were deemed a danger to self and / or others ?

___ Yes ___No

If yes please give dates and explanation _____

_____

_____ Date: _____
Signature

Broken Chains Christian Counseling Inc.
13000 N. 103rd. Ave. Suite 79
Sun City, Az. 85351
P: (623)533-5138 F: (623)533-4271

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Client's Name : _____

Date of Birth (day/ month/ year): _____

I hereby authorize the following designated office or person of Broken Chains Christian Counseling Inc. to release or request the following personal information about me:

___Request reports(s) From: _____

___Request written reports(s) from: _____

___Release information to: _____

___Release written information to : _____
(agency, organization, school, hospital, professional, etc.)

The following information: _____

_____

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year, from signed date

Signed: _____ _____ _____
(Client 12 years of age and older) Date Witness

Signed: _____ _____ _____
(Parent or legal guardian) Date Witness

Broken Chains Christian Counseling, Inc. (BCCC)

PERSONAL HISTORY

Listing of relationships and support systems

Name	Age	Relationship (Spouse, Son, Daughter, Other)	Living with you Y/N

Number of previous marriages: _____

*** LIST OR DESCRIBE WHAT CHANGES YOU WANT TO MAKE WHILE IN COUNSELING AND WHAT YOUR CONCERNS ARE:*

_____

_____

_____

_____

_____

_____

What causes the problem(s)? _____

When did it start? _____

MEDICAL HISTORY:

Are you currently under the care of a physician? _____ Yes _____ No

Reason? _____

_____

When was your last checkup? _____

Current medical issues: _____

_____

_____

_____

Please list any prescriptions or over the counter MEDICATIONS you are currently taking and the prescribing DOCTOR:

Medication	Prescribing Doctor	Doctor Address	Doctor Phone

TREATMENT HISTORY:

Have you ever received counseling for any reason? (if yes, please list when and why)

Have you ever been hospitalized for a psychiatric reason? (if yes, please list when and why)

Have you ever been hospitalized for medical issues? (if yes, please list when and why)

Have you ever received treatment for Drugs or Alcohol? (if yes, please list when and why)

Have you ever attended any self-help groups as AA, CODA, OA, etc.?

Broken Chains Christian Counseling, Inc. (BCCC)

WEIGHT HISTORY - describe problems in the last 6 months

- Weight unchanged / no problems
- Weight gained?_____ Was weight gain intentional? _____
- Weight loss ?_____ Was weight loss intentional ? _____
- Purging _____
- Binging _____
- Laxative use _____
- Diuretic _____
- Diet pills use _____

Comments : _____

Sleep History - Describe problems in last 6 months

- **Sleep unchanged / no problems** _____
- **Can't fall asleep** _____
- **Can't wake up** _____
- **Sleep constantly**_____
- **Can't stay asleep, wakes up early** _____
- **I sleep, but don't feel rested** _____
- **Nightmares** _____

Comments: _____

SELF MUTILATION: (i.e. cutting) ___No ___ Yes, current ___ Yes, in the past
SUICIDAL THOUGHTS: ___No ___ Yes, current ___Yes, in the past
SUICIDAL PLAN or INTENT: ___No ___ Yes, Current ___ Yes, in the past
(If yes, # of Attempts) _____

If you are currently physically hurting yourself, or if you intend to hurt yourself or end your life, do you have a plan ? (please explain) _____
_____

HOMICIDAL THOUGHTS: ____ No ___Yes,current ___Yes, in the past
HOMICIDAL PLAN OR INTENT: ___ No Yes, current ___ Yes, in the past
(If yes, # of attempts) _____

If you feel like hurting someone now, do you have a plan? (if so, please explain)_____
_____

Have you ever been violent or hurt someone?____**No**____**Yes (Please explain)**_____

_____

_____

_____

Broken Chains Christian Counseling, Inc. (BCCC)

SUBSTANCE ABUSE HISTORY

Do you or have you ever had a substance abuse problem? ___ No ___ Yes ___ in the past

If yes, or in the past, please explain what type of drug and how you used i.e. drank, snorted, smoked, IV, etc.

_____

_____

The duration of use and at what age did you start using? _____

_____

Most recent time using _____Type of drug: _____

The amount used:_____ Have you ever overdosed on drugs or alcohol? ___ No ___ Yes

(if yes, how many times?) _____ Dates of overdose, and what happened? _____

_____

Was any of your overdoses intentional? ___ No ___ Yes (if yes, please explain) _____

_____

FAMILY USE:

Is there a family history of substance abuse? ___ No ___ Yes (if yes, please explain) _____

_____

Do you believe someone in your family, or someone you care about might have substance abuse problems? ___ No ___ Yes (if yes, then who, and how does their use affect you?) _____

_____

_____

ALCOHOL RELATED EXPERIENCES WITHIN THE PAST YEAR: (circle all that apply)

Binges	Job problems	Physical withdrawal	Arrests	Assaults
Hangovers	Blackouts	Medical complications	DUI	Detached and numb

Other: _____

Thank you for filling out your intake form. Is there anything else you would like us to know?