Broken Chains Christian Counseling Inc.

Phone 623-533-5138 Fax 623-533-4271

PERSONAL INFORMATION FORM (All fields highlighted in red must be completed)

Name of Primary Person Receiving Counseling _____

The Name you would like to go by _____

Address _____City_____Zip_____

DOB: _____ Email Address _____

Cell Phone # _____ Home Phone # _____

I give permission for BCCC to send reminder calls by way of: (Please circle) TEXT or EMAIL

AHCCCS PATIENTS ONLY
Do you have a case manager Yes_____ No_____ If yes, Name & Phone # _____

_____

*It is mandatory that case manager be listed on Release of Patient Information Sheet. (Page 11)

Emergency Contact (name, phone & relationship) _____

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

EMPLOYER: _____ Occupation: _____

Highest Level of Education: _____

Spouse/Partner's Name: _____Occupation: _____

RELIGIOUS AFFILIATION: _____ Currently Active? _____

How Did You Hear About Us? _____

Broken Chains Christian Counseling Inc

Insurance Information

Primary Health Insurance Plan _____

_____

Policy Holder's Name _____

Policy Holder's DOB _____

Policy Holder's Social Security # _____

Health Plan ID _____

Group ID _____

Secondary Health Insurance Plan _____

Policy Holder's Name _____

Policy Holder's DOB _____

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 my information needed top bill my insurance.

_____

Signature Date

Broken Chains Christian Counseling Inc.

FINANCIAL POLICY

_____
_

First Name Middle Initial Last Name

Thank you for choosing Broken Chains Christian Counseling (BCCC) 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 send my Insurance card, picture id, referral, and or co-payments, that my appointment may be rescheduled until such time that I can provide that required documents or payments.

Initial _____

2) I understand that BCCC 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 BCCC.

   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 contract BCCC 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 THAT LEAST 24 HOUR ADVANCED NOTICE.

Initials _____

5) I understand that if my account is not paid in 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) BCCC 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 a claim for services. It is also my responsibility to notify BCCC 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

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 are rates for SERVICES NOT COVERED by most insurances:

Tele-mental-health Counseling (1hr)

(Licensed Master's Level) ie; LCSW, LPC, LMFT, CTMH	$175.

Tele-mental-health Counseling (30 min)

(Doctorate Level) ie; PhD, Psy D	$125.
(Licensed Master's Level) ie; LCSW, LPC, LMFT, CTMH	$100.
(Associate Master's Level-Needing Supervision) ie; LCSW, LPC, LMFT, CTMH	$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

Broken Chains Christian Counseling Inc

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 form 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 your insurance company.

*Exceptions may be decided at the discretion of our Provider or Office Manager.

COURT APPEARANCES

***IN PERSON COURT APPEARANCES** regardless of the time spent at court will be charged. $1,500.

***TELEPHONIC COURT APPEARANCES** regardless of time on the phone will be charged. $750.

*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 ½ hour self-pay fee will be charged at $100 payable prior to being faxed.

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

_____

Signature Date

Broken Chains Counseling Inc

Informed Consent

- Receive high-quality service
- Be treated with respect and courtesy
- Have your information kept private and confidential except as described in BCCC'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

With my signature I agree with all the above

Signature of client or legal guardian_____

Print Name _____

Date _____

Broken Chains Christian Counseling Inc

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, Trudy M Soncrant MSW, LCSW, LISAC, CTMH, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and or breaches of confidentiality by unauthorized persons, and or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (ie mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in serviced interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 602-377-8324 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location incase of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In Case of an Emergency, My location is: _____
_____

My Emergency Contact person's name, address, phone:_____
_____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Signature of client, patient or legal guardian Date

_____

Signature of therapist Date

Broken Chains Christian Counseling Inc

Legal History

Is this counseling mandatory? Yes_____ No _____ If Yes, please explain _____

_____

Are you a United States Citizen? Yes _____ No _____

Have you ever been arrested or been involved as a victim of dispute for any reason? Yes _____No_____

Alcohol, Drug Legal History

Drug related, for any reason? Yes_____ No _____ If yes please give dates and explanations.

_____

_____

DUI? _____

History of Domestic Violence

History of being a Perpetrator of Domestic Violence?

_____

_____

History of Domestic Violence Victim?

_____

_____

Other Legal History?

_____

_____

Child Custody Dispute History?

_____

_____

Fraud, Felony or Misdemeanor Other than driving?

_____

Sexual Crimes? _____

Indecent Exposure? _____

Broken Chains Christian Counseling Inc

Legal History Continued

Have you ever been imprisoned, incarcerated or confined for any reason? Yes _____ No _____ If Yes, Please give dates and explanations

_____

_____

Have you ever been petitioned against your will because you were deemed a danger to self or others? Yes _____ No _____ If Yes, please give dates and explanation _____

_____

_____

Do you have a crisis plan or a Psychiatric Advanced Directive in place? Yes _____ No _____

Would you like information on Psychiatric Advanced Directives? Yes _____ No _____ If Yes, was this given to you? Yes _____ No _____

Barriers to Treatment

Are there any spiritual or religious barriers which could affect treatment?

_____

_____

Are there any medical problems which may affect treatment?

_____

Any other barriers affecting treatment?

_____

Are you currently utilizing community resources? If so, please list.

_____

_____

Broken Chains Christian Counseling Inc

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Please make additional copies for each person/office you want info released to.

Client's Name: _____

Date of Birth: _____

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 report(s) from: _____

☐ Request written reports from: _____

☐ Release information to: _____

☐ Release written information to: _____

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 yrs of age & older) Date Witness

Signed: _____

(Parent or legal guardian) Date Witness

Broken Chains Christian Counseling Inc

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 caused the problem(s)?_____

_____

When did it start? _____

Medical History

Are you currently under the care of a physician? Yes _____ No _____
Reason? _____
Physicians Name, Address & Phone _____
_____
When was your last check up? _____
Current medical issues? _____
_____
Allergies to medications? Yes _____ No _____ If Yes, Please List _____
_____
Common Allergies? Yes _____ No _____ If Yes, Please List _____
_____
Do you smoke cigarettes? Yes _____ No _____ If Yes, How Long? _____

Please list any prescriptions or over the counter Medications you are currently taking and the prescribing Doctor:

Broken Chains Christian Counseling Inc

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

Weight History

Weight unchanged / No problem
Weight gained? _____ Was weight gain intentional? _____
Weight Loss? _____ Was weight loss intentional? _____
Purging?_____
Binging? _____
Laxative use? _____
Diuretic use? _____
Diet pills use? _____

Comments: _____

Sleep History – Describe problems in last 6 months
Sleep unchanged / No problems _____
Can't fall asleep _____
Can't wake up _____
Can't stay asleep, wake up early _____
I sleep, but don't feel rested _____
Nightmares _____

Comments: _____

Self-Mutilation (Ie Cutting) Yes _____ No _____ Yes, in the past _____
Suicidal Thoughts Yes _____ No _____ Yes, in the past _____
Suicidal Plan or Intent Yes _____ No _____ Yes, in the past _____

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

Have you ever been violent or hurt someone? Yes _____ No _____ If yes, please explain_____
_____
_____

Broken Chains Christian Counseling Inc

Substance Abuse History

Do you or have you ever had a substance abuse problem? Yes ◯ No ◯ In the past ☐
If yes in the past, please explain what type of drug and how used ie drank, snorted, smoked, IV, etc.

_____

_____

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? Yes ◯ No ◯ If yes, how many times? _____
Dates of overdose and what happened? _____

_____

_____

Was your overdose intentional? Yes ◯ No ◯ If yes, please explain _____

_____

_____

Family Use

Is there a family history of substance abuse? Yes ◯ No ◯ If yes, please explain _____

_____

_____

Do you believe someone in your family, or someone you care about might have substance abuse problems? _____

_____

Alcohol related experiences within the past year: (Check 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? _____

_____