**Client Information**

|  |  |  |
| --- | --- | --- |
| Name: | Full Name | Date |
| Address: | Address | City | State | Zip Code |
| Phone: | Home Phone | ­Cell Phone |  |
| Email Address: | Email Address |

May we communicate with you via voice/text/email message(s) at: [ ]  Home [ ]  Cell [ ]  Work [ ]  Email

Would you like an appointment reminder call? Yes [ ]  No [ ]

Would you like your billing statements emailed? Yes [ ]  No [ ]  If no, we will mail it to your home address.

|  |  |  |  |
| --- | --- | --- | --- |
| Birth Date: | MM/DD/YYYY | Social Security Number: | \_\_\_\_-\_\_\_-\_\_\_\_ |
| Marital Status: | Choose Status | Spouses/Partners Name: | Spouse/Partners Name |
| Child(ren) Data: | Child Name (Age) | Child Name (Age) | Child Name (Age) | Child Name (Age) |

**Cash Pay Client:**

Are you a cash pay client? Yes [ ]  No [ ]  If no, please fully complete the insurance information below.

**Insurance Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Company: | Insurance Company | Insurance Policy Holder: | Policy Holder Name |
| Policy Holder Birth Date: | MM/DD/YYYY | Policy Holder SSN: | \_\_\_\_-\_\_\_-\_\_\_\_ |
| Insurance Address: | Address | City | State | Zip Code |
| Policy # | Policy Number | Group ID # | Group Number |

**Responsible Party Information (If client is under 18):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Full Name | Social Security Number: | \_\_\_\_\_-\_\_\_-\_\_\_\_ |
| Birth Date | MM/DD/YYYY | Relationship to Client: | Choose an item. |
| Is address same as above? Yes [ ]  No [ ]  If no, | Address |

**Emergency Contact:**

In an emergency, should we contact someone? No [ ]  Yes [ ]  If yes, please list their information below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | Full Name | Relationship: | Relationship | Phone: | Phone Number |

**Referral:**

Were you or the client referred? Yes [ ]  No [ ]  If yes, who referred the client? Name of Referral

Please explain your reason for coming in today:

|  |
| --- |
| Please explain in detail |

*Previous Treatment*, if any:

 Please explain in detail

*Income* – Identify all sources and amounts (job, alimony, rentals, etc.):

Please explain in detail

*Employment -* Are you employed? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, name of employer: | Company Name |
| Company Address | City | State | City |

 *Sleep* – Please describe your sleeping patterns:

 Please explain in detail

*Exercise* – Please describe what you do for exercise, and how often:

Please explain in detail

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All of the information contained in this form is CONFIDENTIAL. However, if my counselor and I agree that it would be beneficial to me to contact another health care provider to discuss my case; I hereby give my permission to release pertinent information about my case to an appropriate provider. I understand that no information will be released without my prior consent.

**Current Medications**

It is very important for us to know the medications you are taking in order to properly direct your treatment. Please complete the following:

|  |  |  |
| --- | --- | --- |
| Client Name: | Full Name | MM/DD/YYYY |
| Prescribing Physician(s): | Physician Name | Additional Physician Name |
| Main Physician Address: | Address | City | State | Zip Code | Phone Number |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications** | **Dosage** | **Times Taken** | **Purpose** |
| Name | Ex: 4 mg | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |
| Name | Amount | Select Option | Purpose |

\*\*\*If no medication currently prescribed please acknowledge by signing below.

|  |  |  |
| --- | --- | --- |
| No Medication: | Client/Guardian Signature | MM/DD/YYYY |

**Consent for Treatment**

I, Client/Parent/Guardian Name give permission to Sierra Counseling & Neurotherapy to treat Client Full Name. In signing this consent, I give permission to Select Clinician to act as the primary clinician. I am aware that when giving my consent for treatment I am given the right to obtain all information having to do with the counseling sessions. I am allowing Sierra Counseling and Neurotherapy to provide Client Full Name with the following services:

**Please check which services you will be obtaining:**

|  |  |
| --- | --- |
| [ ]  Individual Therapy | [ ]  Neurotherapy / Biofeedback Therapy |
| [ ]  Marriage & Family Counseling | [ ]  TOVA Testing |
| [ ]  Substance Abuse Counseling | [ ]  Micro Cog Testing |
| [ ]  Alcohol & Drug Evaluation | [ ]  Psychological Testing (e.g., I.Q. Test) |
| [ ]  Anger Evaluation | [ ]  QEEQ |
| [ ]  Anger Management | [ ]  Telehealth |

By signing this form, I certify I have read or had this form explained to me.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |

**Telehealth Agreement and Conditions**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: | Full Name | Date: | MM/DD/YYYY |

1. I understand that my health care provider is offering me the opportunity to engage in telemedicine services and has explained to me how the telehealth conferencing will be used.
2. I understand there are potential risks to this technology including: interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth session if it is felt that the telehealth conferencing or connections are inadequate or inappropriate for the situation.
3. I understand that my healthcare information will be shared with other individuals within the organization for scheduling and billing purposes. Billing will be accomplished as appropriate for a telehealth session and in accordance with the regulations and policies of your insurance companies as well as professional practice. Your insurance company will determine the requirements regarding copayments and deductibles and related issues.
4. Confidentiality will be maintained regarding session content and participation will follow the normal ethical and legal requirements about sessions generally provided and as outlined in the Statement of Confidentiality Form (pg. 8).
5. Both the client and therapist will ensure that the session occurs in a setting that is appropriate regarding confidentiality and conduct. In the event that other people are present or later enter the session, that information will be immediately disclosed and, whenever possible, the other participants will remain within the view of the video or otherwise make their presence obvious.
6. In the event of technical or other difficulties during the session, backup arrangements for continued contact will be in place.
7. I have had the alternatives to the telehealth session explained to me and I am choosing to participate in telehealth sessions until further notice.
8. I have had the opportunity for direct conversation with my therapist or designated staff during which I have had the opportunity to ask questions regarding this procedure. My questions have been answered and the risk, benefits and any practical alternatives have been discussed with me in a language which I understand.
9. By signing this form, I certify I have read or had this form explained to me; I fully understand its contents including the risks and benefits of this methodology, and I have been given ample opportunity to ask questions and the responses have been answered to my satisfaction.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |

**Contacting Your Insurance Company**

Insurance companies vary substantially in the coverage which they provide for counseling and biofeedback services. Some companies require preauthorization before you see a therapist; other companies require authorization for continuing visits or certain types of services. Some companies require that the policy holder contact the company and others require the therapist provide the necessary information. This can be very confusing but do not give up; it is possible to get the information you need. The first place to check about your benefits is in your insurance manual or with your employer. Following that you may need to make a telephone contact with the insurance company to determine the rules which apply to your coverage for the type of counseling services being considered.

The following are some questions which you might ask your insurance carrier to clarify your benefits.

1. Do you cover counseling (or neurofeedback or substance abuse or pain management)?
2. If yes, is it under the medical or psychological part of the policy?
3. Will you pay for this service for (your condition)?
4. At what rate to you reimburse?

Insurance companies may reimburse at different rates depending on whether services are under PPO, HMO or out of network. They may also have a maximum rate or percentage for a condition.

1. What is my deductible? Have I met my deductible for the year?
2. What is my co-payment?
3. How many sessions of treatment are available each year?
4. Is there a limit the company will pay for this type of treatment?
5. Must I have a referral, letter, or prescription from my doctor for this service?
6. Is my counselor at Sierra Counseling & Neurotherapy on the company’s provider list? If no, does the company have provisions for unlisted providers?
7. Are there any other special requirements for you to obtain services under the company’s policy?

Although it may take some effort to obtain this information, it will help you to be clear about the requirements and benefits of your insurance as it pertains to the services. If after your contact with your company, you still are unclear about some points or need additional help, we will gladly lend a hand. A verbal confirmation of payment by your insurance company is ***not*** binding and determination of payment is unknown until a claim has been processed. Insurance companies will send you an Explanation of Benefits (EOB) to inform you of the claim stats and rationale, meeting the requirements for your insurance company is your responsibility.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |

**Financial Agreement**

I authorize the direct payment of any benefits due to me for the services provided by Sierra Counseling & Neurotherapy are paid directly to Sierra Counseling & Neurotherapy by my insurance company.

I realized that although Sierra Counseling & Neurotherapy may be billing my insurance company on my behalf, I am ultimately responsible for the balance on my account. Failure to provide a copy of my insurance card at time of service and the claim is denied for “no authorization” or “timely filing,” you may be responsible for any unpaid balance by insurance.

***Medicare Client:*** I understand that Sierra Counseling & Neurotherapy accepts assignment with Medicare; however, I am responsible for a 20% coinsurance and yearly deductible. Sierra Counseling & Neurotherapy will bill my supplemental insurance if I provide all the information necessary to do so. I understand that Medicare only pays for services it considers to be medically necessary and that the case may arise that I request services Medicare will not pay for.

***Insurance Client:*** I understand that I am responsible for knowing what benefits are covered by my insurance policy. I understand that Sierra Counseling & Neurotherapy will try to verify benefits but does not guarantee any service will be a covered benefit. I understand that if my insurance does not cover any services received, I will be responsible for payment. I understand that my co-pay is due and payable at the time of service.

***Self-Pay Client:*** I understand that it is the policy of Sierra Counseling & Neurotherapy to collect payment for services at the time of service. I understand that if I pay in full at the time of services, I will be entitled to a cash pay discount of 10%.

***Electronic Billing Statements:*** I understand that I will receive a billing statement to my email address provided above.

***Return Check:*** If your check is returned by the bank unpaid, our office will charge you the amount of your check plus $15.00 and any bank fees associated with the return of the check.

***Collection Agency:*** Any unpaid balances in which the client is responsible will be turned over to a collection agency after reasonable efforts at collection by our billing company have been made. I understand that I will be responsible for all additional costs associated with this collection process.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |

**Statement of Confidentiality**

Counseling is a very private matter between the counselor and the person being counseled. We respect the personal and private matters that you choose to share in counseling, and we do not, in any way, wish to misuse that trust. Our professional ethics and the Nevada Revised Statue require that the information you provide remains confidential with your counselor, or when necessary, with principal staff of Sierra Counseling & Neurotherapy and that it only be shared with others outside our facility with your written and informed consent.

At times, it may be required by law or by professional ethics to disclose information to specific agencies or individuals. These exceptions include:

1. When there is suspected or acknowledged child abuse.
2. When there is suspected or acknowledged abuse of an elderly person.
3. When there is suspected or acknowledged abuse of a disabled person.
4. When there is strong reason to believe that there is significant danger to you or someone else.
5. Under the Employee Assistance Program, information regarding confidentiality is included in your company’s contract. Typically, disclosure under such contracts is limited to supervision referrals in which attendance at counseling is disclosed.
6. If legal means are required to collect your bill, information on client status and financial agreements may be disclosed to the court.
7. Infrequently, in matters such as child custody disputes or where the court is otherwise involved, the court can order records to be released, and counselors can be ordered to testify.
8. If your records are protected under the federal drug and alcohol statues, there are conditions when we may not be able to release records even with your permission.

We want you to fully understand these exceptions, however, be assured that these are the exceptions to confidentiality, rather than the rule. When such exceptions do occur, you will be notified. This is not intended to be a legal description of confidentiality, but to provide some basic information for your use. If you need further information, please let us know.

I have read and understand this statement of confidentiality.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |

**Qualified Provider Form**

I understand that it is my right as a client of Sierra Counseling and Neurotherapy to have the opportunity to select a qualified mental health provider. If there is not a provider on the staff of Sierra Counseling and Neurotherapy who meets my choice, I will be helped in identifying another qualified mental health provider in the community who is appropriate. This matter has been fully explained to me and any questions answered to my satisfaction.

**No Call No Show**

In order to maintain my appointment(s) at Sierra Counseling & Neurotherapy, I understand that I must call SCN when I cannot make the scheduled appointment. If no one answers, I know that I can leave a detailed message. If two (2) no call, no show occurs, all remaining scheduled appointments will be cancelled if my therapist approves.

In the event that all remaining scheduled appointments are cancelled but you wish to reschedule, please do not hesitate to contact our office and schedule an appointment.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |

**Client Rights**

**As a recipient of services with Sierra Counseling & Neurotherapy, you have the right to:**

1. Be provided treatment appropriate to your needs, as they are available at our facility.
2. Obtain services from any provider you choose and for which you are eligible.
3. An explanation of any transfer to another provider and alternatives available (unless such a transfer is made due to a medical emergency).
4. Have your clinical records forwarded to a receiving program if you are transferred/referred to another program.
5. Be informed of all services which may be of benefit to your treatment.
6. Be informed of the name of the person and the professional qualifications of the person responsible for coordination of your treatment and staff involved in your treatment.
7. Be informed of your diagnosis, treatment plan and prognosis.
8. Be given sufficient information for you to give consent to any treatment provided, including significant medical risks, estimate of costs of treatment, and description of an alternative to treatment.
9. Be informed if the clinic proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.
10. Examine your bill for treatment and receive an explanation of the bill.
11. Be informed of the clinic’s rule for your conduct at the office.
12. Refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
13. Receive respectful and considerate care.
14. Receive continuous care; be informed of your appointments, the names of the clinic staff available for treatment, and any need for continuing care.
15. Have any reasonable request for services reasonably satisfied by the clinic, considering its ability to do so.
16. Safe, healthful, and comfortable accommodations.
17. Confidential treatment. This means that other than expectations defined by law such as those in which public safety takes priority, without your explicit consent, the clinic may release no information about you, including confirmation or denial that you are a client.
18. Know that a waiver of any civil or other right protected by law cannot be required as a condition of treatment.
19. Freedom from emotional, physical, intellectual, or sexual harassment or abuse.
20. Be informed of your rights as a client. The foregoing is to be made immediately available to you, and you are to be informed of these rights and given a listing of them as soon as practically possible upon beginning treatment.
21. Client Acknowledgement: I have read, understand, and can request a copy of the above Client Rights.

|  |  |
| --- | --- |
| Client/Parent/Guardian Printed Name | MM/DD/YYYY |
| Client/Parent/Guardian Signature | MM/DD/YYYY |