CARE and COUNSELING
Hope and Healing

12141 Ladue Road • St. Louis, MO • 63141-8120
314-878-4340 Phone • 314-878-4524 Fax
info@careandcounseling.org • www.careandcounseling.org

Accredited by The Samaritan Institute

Therapist: _____

AGREEMENT FOR PAYMENT AND FINANCIAL RESPONSIBILITIES

Care and Counseling is a non-profit pastoral counseling center. The standard fee for a 1st evaluation appointment is $190 and the standard fee for ongoing counseling is $175 per 38-67 minute session. We also have a Client Assistance Fund for those whose income cannot support the standard fee. Annually we review fees and renew the agreement for payment. There is a cost of living increase typically 1-2% each year. Please complete the following and return to your counselor.

Client's Name:_____ **SS#:**_____

Address:_____**City:**_____**State:**_____**Zip:**_____**County:**_____

Home Phone:_____**Cell Phone:**_____**Work Phone**: _____

DOB:_____**Age:**_____**Sex:** ☐ M ☐ F **Marital Status:** ☐ **S** ☐ **M** ☐ **D** ☐ **W** **Email:**_____

Employer / School:_____ **Occupation / Year:**_____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_____

Spirituality: _____**Importance to You:**_____

Parent or Guardian (if under 18)_____

Who Referred You? Name:_____Phone:_____

May your therapist acknowledge the referral? ☐ Yes ☐ No

☐ I would like to be placed on the Care and Counseling mailing list to receive newsletters and other center information.

Emergency Contact: Spouse/Partner/Other: **Name:**_____ **Relationship:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Permission to Call: ☐ **Yes** ☐ **No** **Restrictions?**_____

Secondary Client's Name:_____ **SS#:**_____

DOB:_____**Age:**_____**Sex:** ☐ M ☐ F **Marital Status:** ☐ **S** ☐ **M** ☐ **D** ☐ **W** **Email:**_____

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_____

Continued on Next Page

Please list any additional people who will be attending the counseling session

Additional Name (As needed):____ **SS#:**______________________________

DOB:_________**Age:**________**Sex:** ☐ M ☐ F **Marital Status:**☐ **S** ☐ **M** ☐ **D** ☐ **W** **Email:**_________________________

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_________

Additional Name (As needed):____ **SS#:**______________________________

DOB:_________**Age:**________**Sex:** ☐ M ☐ F **Marital Status:**☐ **S** ☐ **M** ☐ **D** ☐ **W** **Email:**_________________________

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_________

Additional Name (As needed):____ **SS#:**______________________________

DOB:_________**Age:**________**Sex:** ☐ M ☐ F **Marital Status:**☐ **S** ☐ **M** ☐ **D** ☐ **W** **Email:**_________________________

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_________

Additional Name (As needed):____ **SS#:**______________________________

DOB:_________**Age:**________**Sex:** ☐ M ☐ F **Marital Status:**☐ **S** ☐ **M** ☐ **D** ☐ **W** **Email:**_________________________

Race: ☐ White/Caucasian ☐ African-Am. ☐ Asian ☐ Latino/Hispanic ☐ Native Am. ☐ Multi-racial ☐ Other_________

Continued on Next Page

Household Income: (We need this information whether or not you use insurance or pay a subsidized fee.)

Care and Counseling is a non-profit organization and is able to provide subsidized counseling due to the contributions of our many funders. In order to secure funding, it is often necessary to provide aggregate household income data for our client base, which illustrates our financial need. This figure is to include all sources of income -- i.e. salary, child support, maintenance, investment income, housing allowances. Please check the appropriate range for your gross family income and the number of members living in or financially dependent on your household. Information provided to funders is only given in aggregate form and individual client information is not released.

$0 - 10,000	_____	$40,001 - 50,000	_____	$ 80,001 - 90,000	_____	$120,001 - 130,000	_____
$10,001 - 20,000	_____	$50,001 - 60,000	_____	$ 90,001 - 100,000	_____	$130,001 - 140,000	_____
$20,001 - 30,000	_____	$60,001 - 70,000	_____	$100,001 - 110,000	_____	$140,001 - 150,000	_____
$30,001 - 40,000	_____	$70,001 - 80,000	_____	$110,001 - 120,000	_____	**Number in household**:	_____

☐ I would like to be considered for a subsidized fee. Based on your income, your subsidized fee is:_____

Party responsible for payment: Self:_____Other/Relationship:_____

Please Print Name of Insured

Insurance (The office will need a copy of both sides of your insurance card.)

Primary Insurance:_____Phone:_____

Insured Name:_____DOB:_____ SSN #:_____

ID #:_____Group:_____ Employer:_____

**Authorization # (if required by insurance company):_____

****If I fail to obtain authorization, I am responsible for payment to Care & Counseling for the denied session.**

Secondary Insurance:_____ Phone:_____

Insured Name:_____DOB:_____ SSN #:_____

ID #:_____Group:_____ Employer:_____

**Authorization # (if required by insurance company):_____

****If I fail to obtain authorization, I am responsible for payment to Care & Counseling for the denied session.**

1. I am responsible for obtaining all authorizations and for all charges not covered. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required and waive confidentiality for this purpose).
2. I authorize Care and Counseling staff to communicate with my insurance company for the purpose of claim verification and authorization for services, including a diagnosis code, and for my insurance carrier to release information regarding my coverage to Care and Counseling. I authorize the release of any medical or other information necessary to process this claim.
3. My right to payment for all services are hereby assigned to Care and Counseling. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Care and Counseling.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Care and Counseling.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the terms.

_____ _____

Client Signature or Authorized Persons Signature **Date/Time** AM or PM (circle one)

_____ _____

Responsible Party Signature **Relationship** **Date/Time** AM or PM (circle one)

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HEALTH HISTORY – ADULT

1. Name _____ Date of Birth _____
   Occupation _____ Social Security Number _____
   In Case of Emergency Contact _____
   Phone Number _____ Relationship _____
   Children and Ages _____
   _____
2. Primary Care Physician _____ Phone Number _____
3. Serious Medical Illness/Accidents (Identify and give dates) _____
   _____
   _____
4. Are you currently on any medications? □ Yes □ No
   If yes, please list _____
   Any past medications? (May use back of form) _____
5. Surgeries or operations (Identify and give dates) _____
   _____
6. Any hospitalizations? □ Yes □ No
   If yes, when and for what reason _____
7. Have you ever been treated for depression/anxiety? □ Yes □ No
   If yes, by whom? _____ □ Internist □ OB/GYN □ Psychiatrist
   Please list any medications prescribed _____
8. Have you had any previous counseling? □ Yes □ No
   If yes, with whom and when? _____
9. Are you or have you been in the care of a psychiatrist? □ Yes □ No
   If yes, with whom and when? _____
10. Have you ever been treated for alcohol or drug abuse? □ Yes □ No
    If yes, when and where? _____
11. Have you been the victim of physical or sexual abuse? □ Yes □ No
12. Do you have suicidal thoughts? □ Yes □ No
13. Have you had a suicidal attempt? □ Yes □ No If yes, when? _____
14. Do you or have you had an eating disorder? □ Yes □ No
15. Do you have a history of infectious diseases? □ Yes □ No If yes, please describe _____
    _____
16. Do you have any allergies? □ Yes □ No
    If yes, please describe any adverse reactions _____
17. Is there past or present nicotine use? □ Yes □ No

Client Signature: _____ **Date:** _____

Legal Guardian Signature: _____ **Date:** _____

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CONSENT FOR SERVICES

Welcome to Care and Counseling.
Care and Counseling is a non-profit, interfaith counseling agency with a mission to enhance emotional, relational, and spiritual well-being through quality and affordable counseling, professional training, and community education. This document contains important information about the services and policies of Care and Counseling. Please review the information carefully, sign the document, and discuss any questions with your therapist.

Confidentiality
Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. It is the policy of Care and Counseling to protect the privacy of every client to the maximum extent possible. Generally, information about you or services furnished to you will not be released without your prior written consent. There are, however, some circumstances which require the disclosure of information without your consent, such as when:

a) mandated by state or federal law due to suspicion or knowledge of child abuse and/or neglect or elder abuse and/or neglect,
b) there is an imminent risk or serious threat of physical harm to self or to others, and
c) specifically ordered by a court of law.

In accordance with the quality assurance standards set by Care and Counseling's accrediting entity, The Samaritan Institute, your file may be reviewed to ensure record keeping compliance. Also, your therapist may anonymously discuss your treatment with a supervisor to ensure the provision of quality care. All Care and Counseling supervisors and staff are obligated to follow laws of confidentiality.

Cancellation Policy
Care and Counseling requires 48-hour notice in the event you need to cancel or reschedule your appointment. To cancel or reschedule your appointment contact your therapist by calling his / her direct dial phone number, or you may contact the front desk at 314-878-4340 between 8:30am and 4:30pm, Monday through Friday. After hours, you may contact the front desk and select option 4 for the staff directory.

Appointments that are cancelled or missed without the 48-hour notice will be billed to your account in the amount that Care and Counseling would collect if the service had been provided as scheduled. Insurance does not reimburse for missed appointments, therefore you are responsible for payment of this fee. Please discuss with your therapist any questions about the cancellation policy.

Messages
If you need to contact your therapist outside of your scheduled appointment, you may contact him / her by calling the direct dial phone number, or you may contact the front desk at 314-878-4340 between 8:30am and 4:30pm, Monday through Friday. After hours, you may contact the front desk and select option 4 for the staff directory. Messages are reviewed by the following business day. If you experience a mental health crisis please review the section on emergencies below. Please discuss with your therapist any questions about how he / she handles messages.

Emergencies
If you experience a mental health crisis contact the hotline of Life Crisis Services at 314-647-HELP(4357) or 800-273-TALK(8255). Life Crisis Services offers assistance 24 hours per day, 365 days per year. Alternatively, go to the nearest Emergency Room or call 911. Please discuss with your therapist any further questions about how to handle emergencies.

Fees and Insurance
The fee for your first appointment is determined by a Client Service Specialist during the intake process. At the first appointment, you and your therapist will establish the ongoing appointment fee. Payment is expected at the time of your appointment. Care and Counseling accepts cash, checks, MasterCard, Discover, and Visa.

Care and Counseling accepts Medicare and some insurance as in-network, and other insurance as out-of-network. This varies per the individual therapist / provider, so please discuss this further with your therapist. If you select to use your insurance we will assist you in answering basic questions about your benefits, as well as submit claims on your behalf. You will need to provide your current insurance identification care at the time of your initial appointment. Your plan may include deductibles, co-insurance, and co-pays. Ultimately, you are responsible for payment and understanding your insurance policy.

The standard fee is $190 for an initial appointment, and $175 for ongoing appointments. For those whose household income does not support the standard fee, a sliding-fee scale or subsidy through our Client Assistance Fund may be available. Eligibility for these adjustments is required and depends on available resources. Please discuss this information further with your therapist.

Care and Counseling is a not-for-profit counseling center, and timeliness of payments is important. Overdue accounts may result in formal collection procedures.

Client Consent

My signature below indicates that I reviewed this document, agree to the policies, and authorize the services. I accept financial responsibility for payment of services received, and for payment of late cancellations. If I use insurance to pay all or a portion of the charges, I hereby authorize the release of information necessary to process insurance claims filed on my behalf. I acknowledge that I am financial and legally responsible for the full payment of charges for services received in the event my health insurance policy does not cover my claim. I am 18 years of age or older or I have legal custody of this minor child(ren).

Client Name (Print): _____

Client Signature: _____ **Date:**_____

Therapist Signature: _____ **Date:** _____

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a) mandated by state or federal law due to suspicion or knowledge of child abuse and/or neglect or elder abuse and/or neglect,
b) there is an imminent risk or serious threat of physical harm to self or to others, and
c) specifically ordered by a court of law.

In accordance with the quality assurance standards set by Care and Counseling's accrediting entity, The Samaritan Institute, your file may be reviewed to ensure record keeping compliance. Also, your therapist may anonymously discuss your treatment with a supervisor to ensure the provision of quality care. All Care and Counseling supervisors and staff are obligated to follow laws of confidentiality.

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Client Name (Print): _____

Client Signature: _____ **Date:**_____

Therapist Signature: _____ **Date:** _____

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PRIVACY PRACTICES

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the State of Missouri and Illinois to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on 4/14/2003 and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Care and Counseling, Incorporated. These changes could also effect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information.

For treatment, payment and operation purposes we may use or disclose your health information...

1. To other health care providers who are also treating you,
2. To anyone on our staff involved in your treatment program,
3. To any person required by federal, state, or local laws to have lawful access to your treatment program,
4. To receive payment from a third party payer for services we provide for you,
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to, the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities,
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on,
7. In the event of an emergency to a family member, a person responsible for your care, or your personal representative. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency,
8. Mandated Disclosures:
   a) When mandated by state or federal law (i.e. suspicion or knowledge of child abuse or neglect).
   b) When there is an imminent risk or serious threat of physical harm to self or to others (including suicidal or homicidal thoughts).
   c) When specifically ordered by a court of law.

We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization.

We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of Care and Counseling, **you have these important rights:**

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
B. You can ask us for photocopies of the information in part "A" above.
C. We will charge you 40 cents per page for making these photocopies.
D. You have a right to a copy of this notice at no charge.
E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. Your written request must specify the alternative means and location.
F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
G. You can make a written request that we amend the information in part "A" above.
H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003 at which time this rule takes effect.
K. If you request the accounting in "J" above more than once in a 12-month period we may charge you a fee based on our actual costs of tabulating these disclosures.
L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:
   Privacy Officer:
   Stephanie Whitney, MA, ATR-BC, LPC
   Clinical Director
   Care and Counseling
   12141 Ladue Road
   St. Louis, MO 63141-8120
   Telephone: 314-878-4340
   Fax: 314-878-4524
M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

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This is to acknowledge that I have received Care and Counseling's Privacy Notice

Name _____

Signature _____

Social Security Number _____/_____/_____

Date _____

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Appointment Reminders

Care and Counseling is now offering the option for "Appointment Reminders." You can receive an appointment reminder to your cell phone (via a text message), your email address, or your phone (via a computer generated voice message) the day before your scheduled appointment.

Please select **ONE** of the following options:

☐ **Text Message:** I authorize Care and Counseling to send text message appointment reminders to me on my provided cell phone number. Text message charges from my cell phone provider may apply.

Example of text message: "Do not reply-reminder-You have an appointment MON 01/11 at 4:00 PM – If you have any questions please call us at (314) 878-4340 – Name of Counselor

Cell phone number to send text messages to: (_____) _____ - _____

☐ **Email message:** I authorize Care and Counseling to send an email message appointment reminders to me on my provided email address.

Example of email message from ValantApptReminder@reminderXchange.com
Hello,
This is a reminder of your appointment on Monday – 01/11/2016 scheduled for 4:00 PM with Name of Counselor. If you have any questions regarding your appointment, please feel free to contact us at: (314) 878-4340.
Thank you.

Email address to send reminder messages to: _____

☐ **Automated Voice Messages:** I authorize Care and Counseling to send computer generated voice phone message appointment reminders to me on my provided phone number.

Hello. This is a reminder of your appointment on Monday, January 11, scheduled for 4 PM with Name of Counselor. If you need to reschedule or have any questions, feel free to call us at (314) 878-4340. Once again, your appointment is scheduled for Monday, January 11, at 4 PM with Name of Counselor. Thank you.

Phone number for the automated system to call: () _____ - _____

☐ **None of the above:** I will remember my appointments on my own.

I understand that Late Cancellation and No Show appointment fees will still apply.

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am giving my permission to receive appointment reminders as I have noted above. My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.

_____	_____	_____
Printed Name	Signature	Date

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EMAIL CONSENT

CLIENT INFORMATION	
CLIENT NAME:	DATE OF BIRTH:
EMAIL ADDRESS:	

Care and Counseling will use and disclose Protected Health Information (PHI) as defined in the Health Insurance Portability and Accountability Act (HIPAA). Care and Counseling will use reasonable means to protect the confidentiality of PHI sent and received through email. However, because of the risks outlined below, Care and Counseling cannot guarantee the security and confidentiality of email communications, and will not be liable for improper disclosure of confidential information that is not caused by Care and Counseling's intentional misconduct.

The risks of email communication include, but are not limited to:

- Email can be copied, circulated, forwarded, and stored in electronic files;
- Email, whether accidentally or intentionally, can be broadcast worldwide immediately and received by many unintended recipients;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the provider or client has deleted his or her own copy;
- Employers and online services may have a right to archive and inspect emails transmitted through their systems;
- Passwords providing access to email can be stolen and misused, or host systems can be compromised, leading to unauthorized disclosure of personal information;
- Email can be intercepted, altered, forwarded, or used without written authorization or detection;
- Email may not be answered in the time frame expected by the sender.

After reviewing the risks of email communication, you may authorize (client initials next to selected method):

_____ Encrypted email communication, a secure method, or
_____ Unencrypted email communication, an unsecure method.

By authorizing the above method of email communication, you acknowledge and agree to the following:

- I understand that Care and Counseling will read and respond to email communication as promptly as possible; however, a specific turnaround time is not guaranteed. Thus, I will not use email for emergencies or other time-sensitive matters.
- I acknowledge that some or all information sent or received via email may concern my diagnosis and/or treatment. Email may be included in my medical record or forwarded internally to other Care and Counseling staff as necessary for diagnosis, treatment, payment, and other business purposes. Electronic information will not, however, be forwarded to independent third parties without my prior written consent, except as authorized or required by law.
- I understand that communication via unencrypted email is not secure and, therefore, Care and Counseling cannot guarantee the confidentiality of electronic PHI.
- I understand that Care and Counseling and its representatives are not liable for breaches of confidentiality caused by any third party or myself.
- I understand that I may, at any time, revoke my consent for email communications.
- Unless revoked in writing, this authorization will expire upon the later of the following events: 1) one (1) year after the date of my signature, or 2) the date on which I terminate care by Care and Counseling and its providers.

I hereby acknowledge that I have read and fully understand the information provided in this Email Consent.

_____ _____
Client Signature Date

RIGHT TO REVOKE

I request that my provider no longer use email to communicate with me.

_____ _____
Client Signature Date

_____ _____
Provider Signature Date