Client Information Form

Name of Client: ______________________________E-Mail Address: ____________________________

Address: ____City: ___________________________

State: _______________ Zip: __________ Home Phone: _______________ Cell:___________________

Social Security Number: ___________________ D.O.B.: ________Age: ____ Male: ____Female:____

Employer: _________________________ Job Title:_________________ Work Phone:_______________

Status (please check):

__Single __Married __Separated __Divorced __Widowed __Child __Student

Who referred you to this office? ____

Briefly state the nature of the problem: ____

Family Physician? _____________________________ Phone: _________________________________

Billing information

Name of the person who will assume responsibility for payment

____Check if same as above

Name: ____ SSN: _______________________

Address: _______________________________City: _______________ State ____ Zip ____________

Relation to patient: _________________________ D.O.B. _______________________ Age: _____

Home Phone: _____________________ Cell: _____________________

Insurance Information

Name on Card: ____ Card Holder D. O. B. _____________

Insurance Company Name: ____

I.D. Number of Insured: ________________________ Group Number: __________________________

Policy Number: ____________________ ____________Insurance Phone: _______________________

If there is an additional insurance carrier, please list: ____

STATEMENT: I hereby authorize release of information necessary to file claims, obtain pre-certification of benefits, or verification limits of coverage with my insurance company.

Signature: ____ Date: __________________________

CONSENT FOR TREATMENT, ACCEPTANCE OF FINANCIAL RESPONISBILITY & ASSIGNMENT OF BENEFITS

(Please read carefully)

I ____, give my consent to
Mental health/nutrition counseling treatment for myself and /or
____(minor children).

In giving my consent I do agree to work with the therapist to set goals for treatment, to follow the treatment plan mutually agreed upon, and to keep scheduled appointments unless notification is made 24 hours in advance of the session.

I understand that I am entitled to complete confidentiality unless I am considered to be a danger to myself or to others or I have signed a release of confidential information form for my doctor, another therapist, insurance company or other designee. I understand there may be other situations defined by local, state, or federal laws that may require release of confidentiality.

I agree to assign all insurance and or mental health & nutrition therapy benefits to:

Chrisanna G. Harrington, MA, RD/LD, LMHC: yes ____ no ____

I agree to pay for services as agreed upon in the absence of insurance, or a dispute with my insurance company, or for services received and authorized by me that are not covered by my insurance plan. I further agree to pay if my eligibility for coverage by my insurance company cannot be confirmed at this time, or if I or any member of my family is not eligible for coverage, or my coverage has expired at the time services have been rendered or if my services are covered as out-of-network. I hereby take full financial responsibility for payment for any and all services rendered to me, or any member of my family.

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

I have read, understand and agree to all of the above.

Signature: ______________________________ Date: ______________

Relationship to Client: ______________________________

Therapist: ______________________________ Date: ______________

PROFESSIONAL FEES, BILLING AND SERVICES

I understand that contracted fees, co-payments, and other costs are paid at the time professional services are rendered.

You will be provided with a receipt after each session. The annual deductible must be paid before insurance can be billed.

A fee arrangement is normally reached in the first session. I agree to notify my therapist/dietitian in the event my insurance or financial situation changes.

Strict confidentiality will be maintained unless authorization for release of information is given for billing purposes, as required by Law, or as specifically requested by a patient.

FEE ARRANGEMENT

Insurance/Co-Pay ________________ Cash Payment ____________________

Nutrition ________________________ Lap-Band Psycho __________________

Women's Group __________________ Children's Group ___________________

Marriage ________________________ Out-of-network _____________________

Other ____

Instructions ____

____

Patient or Guardian _________________________________ Date _________________

Therapist ____ Date _________________

Cancellation Statement

If the appointment is not met and I fail to cancel 24 hours in advance **I will be charged $25.00**.

I have read and understand the cancellation policy of Nutegra.

Signature: ___________________________________ Date: ______________________

Chrisanna G Harrington, MA, RD/LD, LMHC
20020 Veterans Blvd., Suite 12, Port Charlotte, FL 33954

Signature of Receipt

HIPAA PRIVACY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

I HAVE RECEIVED AND REVIEWED THE HIPAA PRIVACY STATEMENT FOR THE COUNSELING SOLUTIONS CENTER

Signature: ____ Date: ____________________