Therapist: _____

Champion Christian Community Counseling
333 S. Cherry Street
Tomball TX 77375
281-357-4111

Client Information Form

Date: _____ DX Code: _____

_____

_____

Where did you hear about Champion Christian Community Counseling Services:

_____ Yellow Pages _____ Signs _____ Drive By _____ Friend _____ Other

Client Name: _____ SS#: _____ DOB: _____

Person Financially Responsible: _____

Address: _____ City: _____

State: _____ Zip Code: _____Marital Status: _____ Married _____ Single _____ Divorced

Phone: (Home) _____ (Work) _____ (Cell) _____

Children Name(s): _____ Age: _____

Children Name(s): _____ Age: _____

Are you taking any kind of medication? _____ Yes _____ No List medications and dosage: _____

_____

Emergency Contact: (Who should be contacted in case of an emergency?)

Name: _____ Relationship: _____

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Family Physician:

Name: _____ Phone #: _____

Insurance:

Name of Insured: _____ Insurance Carrier: _____

Employer: _____

Carrier Phone #: _____ Insured's SS#: _____

Policy #: _____ Group #: _____

Reason for Counseling: _____

_____

_____

Consent for Services:

I, _____, consent to treatment for psychological and behavior services at Champion Christian Community Counseling Center Outreach Ministry.

Client Name: _____ Signature: _____

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Client History

Please check any of the following symptoms that apply:

_____ Depressed
_____ Anxious
_____ Socially unacceptable Conduct
_____ Problems at work
_____ Anger
_____ Rage
_____ Legal problems
_____ Irritable
_____ Fearful
_____ Frustrated
_____ Fatigued
_____ Feeling worthless
_____ Feeling guilty
_____ Problems with Concentration / Attention
_____ Racing / Confused thoughts
_____ Obsessive thoughts / behavior
_____ Thoughts of death / suicide
_____ Crying spells
_____ Withdrawn
_____ Increased appetite
_____ Decreased appetite
_____ Difficulty sleeping
_____ Nightmares
_____ Low energy
_____ Distracted
_____ Talkative
_____ Restless
_____ Relationship difficulties
_____ Heart palpitations
_____ Excessive sweating
_____ Nausea
_____ Dizziness
_____ Light-headed
_____ Shortness of breath
_____ Trembling
_____ Sexual Impairment
_____ Substance abuse
_____ Other addictive behavior
_____ Poor impulse control
_____ Abuse survivor
_____ Eating disorder
_____ Hearing voices
_____ Visual hallucinations
_____ Diabetes / Hypoglycemia
_____ Thyroid problems
_____ High blood pressure
_____ Seizures
_____ Other (Explain):

Family History: (Describe current living situations, i.e., who lives with you and some of the circumstances past and present).

_____

_____

_____

Educational / Work History: (Include highest grade completed, types of grades, vocational training, types of jobs held, current source of income, and any history of military duty.)

_____

_____

_____

Alcohol and Drug History: (Include quantity and frequency, past and present, problems because of drinking/ drug use, attempts to stop.)

_____

_____

_____

Information and Professional Services Agreement

We are pleased that you have chosen Champion Christian Community Counseling Center: This form gives some information about our professional relationship. CCCC is a community ministry of Just As I Am Baptist Church, a 501c3 Christian organization.

CONFIDENTIALITY

You have the right to confidentiality. No information will be released without your written consent except as required by law. Such exceptions to confidentiality include:

1. We believe you are in imminent danger of hurting yourself or others.
2. We are ordered by a Judge's order to disclose information or if there is a statute requiring such disclosure.
3. If you choose to use your insurance for payment, they will typically request ongoing communication to certify the medical necessity of your continuing treatment.
4. If your therapist is an LPC intern or a therapist with temporary licenses, they are under supervision by a Licensed Professional Counselor Supervisor. During supervision, a therapist may disclose certain information with their respective supervisor who then shares the obligation for confidentiality. The counseling staff at CCCC, work as a team and your therapist may consult with other therapist and supervisors to provide the best possible care for their patients. All staff members abide by the confidentiality policy.

I acknowledge and understand that under the Health Insurance Portability and Accountability Act of 2003 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I have also been given notification of all "HIPPA" requirements concerning privacy policies. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. *(*Talk to your therapist about any confidentiality concerns.)*

RIGHTS AND RESPONSIBILITIES

Rights

- You have a right to be provided with professional and respectful care.
- You have a right to know our assessment of the problem, the recommended treatment, and the resources available to help deal with your situation.
- You also have the right to refuse our suggestions.
- You are welcome to ask your therapist any questions regarding their background, credentials, professional experience, or philosophy.

Responsibilities

- To be honest, open, and willing to share your concerns.
- To ask questions when you do not understand or need clarification.
- To discuss any concerns, you have about your treatment plan.
- To follow the agreed upon treatment plan.
- To report changes or unexpected events related to your problem.
- To keep appointments or to call and cancel within 24 hours prior to your appointment. Otherwise, you will be charged a $75.00 cancellation fee.

Remember that you are responsible for your thoughts, feelings, actions, and growth. We are here to help facilitate that growth to the best of our ability.

PAYMENT INFORMATION

The standard fee is $125.00 for a 60-minute therapy session. It is the same fee for individual, couple, or family therapy. Some fees are based on a sliding scale based on financial situations and on the needs of the individual client.

**There is a $15.00 fee for all returned checks.*

***CCCC will charge a $2.00 processing fee for credit / debit card payments due to the rising cost of credit card fees.*

Insurance

If you belong to a managed care program, we will bill your insurance company if you do so direct. Co-payments or deductibles are payable at the time of service. If the insurance company does not pay, you are ultimately responsible for the fee. In all other instances, you will be expected to pay the full fee at the time of service. We can assist you in filing for reimbursement from your insurance company.

Cancellations

Please give 24-hours advance notice for cancelled appointments. The advance notice is standard policy in our profession. Failure to give appropriate notice will result in a $75.00 cancellation fee. Your signature below shows that you have read and accepted this policy. Failure to sign will result in a referral to another provider.

Signature: _____ Date: _____

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Notice of No Show / Cancellation Fee

Please be aware that there is a $75.00 No Show / Cancellation Fee that will be assessed each instance that a patient does not give at least a 24-hour notice to cancel an appointment or does not show up to a scheduled appointment.

Although this policy has been in effect, this letter is to serve as a reminder so that there will not be any issues in the future. We appreciate your understanding and consideration on this matter.

Patient Signature: _____ Date: _____

Best phone # for appointment reminders: _____

May we send you an automated text reminder to this number? _____ Yes _____ No

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AUTHORIZATION FOR CHAMPIONS CHRISTIAN COMMUNITY COUNSELING TO CHARGE CREDIT CARD FOR SERVICES

Clients Name: _____

Phone Number: _____

Name on Credit Card: _____

Billing Address: _____ Zip Code: _____

Type of Credit Card: _____ VISA _____ Mastercard _____ Discover _____ Health Savings Account Credit Card

Card Number: _____ Expiration: _____

Amount to charge: _____ Security Code (CVC): _____

Signature: _____ Date: _____