**Changes By Choice**

#  **909 Broad Street + Durham NC 27705 + (919) 416-4800**

**www.changesbychoice.com**

**Date:**

**CLIENT INFORMATION**:

Name:

Phone: (Wk) (Hm) (Cell)

OK to leave message? (Yes/No) Wk Hm Cell

Address: City:

State: Zip: Email address: Gender: Pronouns preferred: Date of Birth:

Insurance Company & ID Number:

Others living at home: Marital Status:

Employer: Occupation:

How long have you worked there? How long in this occupation?

Education: (List highest level of education attained)

Primary Physician: Phone:

List any significant health problems:

List any medications you are taking and the dosage:

Have you seen this type of therapist before? YES NO

If yes, when and with whom?

Give a brief description of treatment:

How or by whom were you referred to us?

Person to contact in case of emergency and his/her relationship to you: Phone:

**FINANCIALLY RESPONSIBLE PERSON’S INFORMATION** (if different from above):

Name: Relationship to Client:

Phone:

Address:

Insurance Company & ID Number:

Date of Birth: Employer::

**INFORMED CONSENT**

**Changes By Choice (CBC)** provides administrative support, including billing and collections, to your provider, who is an Independent Contractor. CBC is not a group, partnership, or joint venture. The professionals who contract with it for office space and ancillary services share a similar commitment to providing quality mental health counseling for substance abuse and other compulsive behaviors.

**CONFIDENTIALITY STATEMENT:**

 All information shared in this treatment is confidential except in circumstances governed by law. The HIPAA notice describes confidentiality in greater detail. If you would like your provider to confer with another healthcare professional, including one(s) associated with CBC, you will need to sign a “Release of Information” form. This permission can be revoked by you at any time.

**FINANCIAL AGREEMENT:**

 Your provider will review his/her fee schedule with you. You will pay your provider directly, but CBC may assist in the billing and collections process. Cash, check, cashiers check, Visa, Mastercard, American Express and Discover are accepted. If you would to use a credit, debit, or HSA card, please fill out our “Pre-Authorized Healthcare Form.” Please do not make checks payable to Changes By Choice.

**FINANCIAL POLICY:**

 Your provider will tell you which, if any, insurance plans he or she participates in. If you have insurance which provides coverage for this provider and this treatment, but your provider is not in-network, CBC can assist you in completing your claim forms by providing a statement of services and payments. You are responsible for mailing it to the insurance company and tracking your reimbursement. You may or may not be eligible for out-of-network benefits depending on your particular plan. If your provider is in-network, your signature below permits CBC to share the required information to file claims and accept assigned benefits, and you agree to pay any deductibles and/or copayments.

 Your provider will gladly discuss your proposed treatment with your insurance company if they call the provider and you provide a release. We do not call to request authorizations. **Please note that your provider has opted out of Medicare and you cannot submit these services to Medicare for reimbursement.**

You are responsible for the full fee regardless of your insurance company’s reimbursement policies. An hourly fee will be charged for any additional professional services rendered by your provider at your request, such as phone contacts over 5 minutes, preparation of special forms, medical reports, court time, consultations with other professionals, etc.

**YOUR FULL PAYMENT IS DUE AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE.**

**NO-SHOW AND CANCELLATION POLICY:**

 Individual, couples and family sessions are reserved for you. 24 hours notice is required for cancellation or you will be charged the full session fee.

**EMERGENCIES:**

 Your provider will discuss his or her emergency response policy with you. If the situation is acute, you should call 911 and/or go to your nearest hospital emergency room and ask for the psychiatrist on call.

**STATEMENT OF UNDERSTANDING:**

I have read, understand, and accept the terms of this information sheet and informed consent.

Client Date

Provider Date

Parent or Guardian if minor Date