



PEAK COUNSELING

17105 PARK PLACE STREET
EAGLE RIVER, AK 99577
PATIENT INFORMATION

Name: Last: _____ First: _____ Middle: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Mailing Address: _____

Physical Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Employed? Yes No Married? Yes No Employer: _____

Emergency contact name and phone: _____

Where did you hear about us? _____

Person Responsible For Payment (must be the same person who signs the patient financial responsibility form**):**

Check if same as above

Name: Last: _____ First: _____ Middle: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Mailing Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Employed? Yes No Married? Yes No Employer: _____

Relationship to Patient: _____



Signature (patient or responsible party): _____ Date: _____

Peak Counseling
17105 Park Place Street
Eagle River, AK

PATIENT CARE CONTRACT & FINANCIAL LIABILITY AGREEMENT

Welcome to Peak Counseling, a company of Eric Unruh Counseling, LLC, of Eagle River, Alaska. The following is a statement of our Financial Policy, which we require you read and sign prior to receiving treatment.

INSURANCE & PAYMENT

I hereby authorize the release of pertinent medical information to my insurance carriers for the purpose of treatment and payment. I am aware that health insurance coverage varies and while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of ALL charges for services rendered by Peak Counseling and any other charges as a result of the treatment rendered. I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered medically necessary by my insurance company and that I must pay my co-pay/co-insurance and or deductible at the time of service. I understand I am responsible for informing the office about changes to my policy that may affect my coverage. Insurance companies do not allow us to retroactively bill for services rendered beyond certain time frames. *I understand I will be responsible for full payment of fees if Peak Counseling is not informed in writing about changes to my insurance before services are rendered.*

SELF PAY / NO INSURANCE

I understand that if I do not have insurance, I am expected to pay for my visit in full at the time of service.

NO SHOW FEES

I understand and agree that if I fail to keep my scheduled appointment and I do not give at least 24-hours notice of cancellation I will be charged for the scheduled time. The missed appointment charge will be \$50.00 for the first missed appointment, \$80 for the second and \$140 for three or more missed appointments. I understand that I am solely responsible for this missed appointment fee and that it will not be billed to my insurance.

COLLECTIONS

Payment for services received at Peak Counseling is the responsibility of the patient, regardless of insurance status. In the event the patient fails to pay the balance or fails to set up a payment plan to Peak Counseling within ninety (90) days of the date of service, the patient's account may be turned to collection. In the event it is necessary to turn your account over to collection, you understand that you will also be responsible for any and all costs of collection, including attorney fees and interest charges.

PRIVACY AND COMMUNICATION

I understand that the phone number or email address that I supply can be used by the staff of Peak Counseling to contact me about any matter and leave a message if needed. During that communication, the staff of Peak Counseling is allowed to identify who they are and that they are calling from Peak Counseling. If another person answers the phone at the given number, the staff of Peak Counseling is allowed to leave a message with that person and identify who they are and supply them with their contact information.

I understand that I will receive a bill to the address I supply detailing what insurance has paid and/or what is owed. This bill will state what services were given and the name of the "responsible party" on the front envelope. The bill will be delivered by the United States Postal Service from Peak Counseling on a regular basis. The mailed envelope will also have the return address to Peak Counseling on the upper left hand corner.

I have read and fully understand the Patient Financial Agreement as outlined above. I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing. I consent to treatment by the staff of Peak Counseling for myself, or my child.



Patient Or Guardian Signature_____

Date_____

Patient Printed Name_____

CONSENT TO TEXT OR EMAIL FOR APPOINTMENT REMINDERS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment and/or provide other general communication related to Peak Counseling. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by e-mail or text could be lost, delayed, intercepted, delivered to the wrong address or arrive incomplete. If you understand these risks, you need to confirm you accept responsibility for these risks and will not hold us responsible for any event that occurs after we send the message.

I consent to receive text messages from Peak Counseling at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/communication/information unless I request a change in writing.

Please check reminder option below (text, email – or both text and email)

___ I prefer to use my **cell phone** for appointment reminders.

Cell Number: _____

Cell Phone Carrier: (Why do we need this info? Your cell number actually has an email address. For example, if your cell number is (555) 555-5555 with GCI, people can email you a text message to your phone at 5555555555@mobile.gci.net. Since our system only works by email, we need to know your carrier so we can text you via email.)

Circle: GCI ATT Verizon T-Mobile Sprint (Other _____)

___ I prefer to use my **email** address for appointment reminders:

Email Address: _____

By signing below, I consent to receive appointment reminders and other communications/information at that email or text address listed above.



Signature: _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA)

I have read or have been offered to read the Health Insurance Portability and Accountability Act (HIPAA) forms before I started treatment with Peak Counseling (a Company of Eric Unruh Counseling, LLC).



Signature: _____ Date: _____

AS 08.29.200. Confidentiality of Communications.

- (a) A person licensed under this chapter may not reveal to another person a communication made to the licensee by a client about a matter concerning which the client has employed the licensee in a professional capacity. This section does not apply to
 - (1) a communication to a potential victim, the family of a potential victim, law enforcement authorities, or other appropriate authorities concerning a clear and immediate probability of physical harm to the client, other individuals, or society;
 - (2) a case conference or case consultation with other mental health professionals at which the patient is not identified;
 - (3) the release of information that the client in writing authorized the licensee to reveal;
 - (4) information released to the board during the investigation of a complaint or as part of a disciplinary or other proceeding; or
 - (5) situations where the rules of evidence applicable to the psychotherapist-patient privilege allow the release of the information.
- (b) Notwithstanding (a) of this section, a person licensed under this chapter shall report incidents of
 - (1) child abuse or neglect as required by AS 47.17;
 - (2) harm or assaults suffered by an elderly person or disabled adult as required by AS 47.24.
- (c) Information obtained by the board under (a)(4) of this section is confidential and is not a public record for purposes of AS 40.25.110- 40.25.140.



Patient Or Guardian Signature _____

Date: _____

REQUIRED DISCLOSURE OF CREDENTIALS & LICENSING INFORMATION

Licensed Clinical Social Workers (LCSW). The following therapist are Clinical Social Workers here at Peak Counseling:

- **Sally Kneeland, LCSW (AK #72)**
- **Eric Unruh, LCSW (AK #647)**

For Clinical Social Workers, Alaska requires that we disclose to our clients how to file a complaint with the state of Alaska if needed:

State of Alaska/DCCED, Division of Corporations, Business and Professional Licensing, Investigations Section, 550 West 7th Avenue, Suite 1500, Anchorage, AK 99501-3567, Phone: (907) 269-8437, Fax: (907) 269-8195.

Website: www.commerce.state.ak.us/dnn/cbpl/Investigations.aspx

Licensed Professional Counselors (LPC). The following therapists are Licensed Professional Counselors here at Peak Counseling:

- **Kendra Bowman, LPC:** Kendra's office title at Peak Counseling is "Therapist". Kendra has a Bachelors of Arts in Psychology from Seattle Pacific University and a Masters of Science in Counseling Psychology from Alaska Pacific University. Kendra has experienced and has special interest treating adolescents and adults with a variety of mental health and behavioral health diagnoses. She offers individual, family and group therapy services

DISCLOSURE OF FEES

Our cash rates for typical services (which may be different than the contracted rate we have with your insurance company) are as follows:

- Initial Assessment: \$281
- 45-50 minute individual session: \$175
- 20-30 minute session: \$122
- Family Therapy: \$181
- Group Therapy 60 minute: \$134

This following information is required by the board of professional counselors which regulates all licensed professional counselors. **Board of Professional Counselors:** Board of Professional Counselors Division of Corporations, Business & Professional Licensing P.O. Box 110806 Juneau, AK 99811-0806 Phone: (907) 465-2551. To file a complaint if needed:

State of Alaska/DCCED, Division of Corporations, Business and Professional Licensing, Investigations Section, 550 West 7th Avenue, Suite 1500, Anchorage, AK 99501-3567, Phone: (907) 269-8437, Fax: (907) 269-8195.

Website: www.commerce.state.ak.us/dnn/cbpl/Investigations.aspx.

Our office information: Peak Counseling (A Company of Eric Unruh Counseling, LLC) 17105 Park Place Street, Eagle River AK 99577. Phone: 907-622-1002

I have reviewed all information in this packet (please sign below)



Signature of Patient or Responsible Party

Date

Print Name



PEAK COUNSELING

17105 PARK PLACE STREET
EAGLE RIVER, AK 99577
WWW.PEAKCOUNSELING.COM
(907) 622-1002

Insurance Eligibility / Authorization Requirements

	<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Name of Insurance	_____	_____
Insurance Phone #	_____	_____
Policy/ID Number	_____	_____
Group Name	_____	_____
Group Number	_____	_____
Name of Insured	_____	_____
Insured D.O.B	_____	_____
SS# of Insured	_____	_____
Employer of Insured	_____	_____

Patient Name: _____
 DOB: _____
 SSN: _____

OFFICE USE ONLY

Insurance Company Phone #: _____
Contact Person Spoken To: _____
Effective Date of Insurance: _____
Currently Eligible: Yes No
Yearly Deductible: \$ _____
Per fiscal calendar year Pre-authorization required? _____
 (fiscal year beginning month of _____ through _____)
Amount of deductible met so far: \$ _____
Co-pay for Outpatient Mental Health: \$ _____
Maximum visits per year: _____
of visits used current calendar year by other providers: _____
Number to call for pre-authorization for mental health authorization: _____
Address to submit Mental Health Claims to: _____