Counselor: _____

# COLUMBIA NORTHEAST COUNSELING SERVICES

9570 Two Notch Road, Suite 8
Columbia, South Carolina 29223
Mailing: Post Office Box 25453, Columbia, SC 29224
PHONE 803-782-5556 FAX 803-788-0914

## INITIAL INFORMATION SHEET

Name: _____ DOB:__/__/__
Last First Middle

Address:_____City_____State_____Zip_____

Gender: ☐Male ☐Female Occupation: _____

Telephone:(H.)_____(C.)_____(W.)_____

E-mail Address: _____

Marital Status: ☐Single ☐Married☐Separated☐Divorced

Religious Affiliation:_____ Minister:_____

Children: (Names and Ages)
1. _____ 2. _____
3. _____ 4. _____

Name of Your Insurance Company: _____
Insurance Address: _____
Primary Card Holder: _____
Relationship to Patient: ☐Self ☐Spouse ☐Child/Parent
Insurance ID Number: _____
Security Number: _____-____-_____

Name of Employer Holding the Policy_____

Employee Assistance Program: _____Number: _____

*Person to Contact in Emergency: _____
Phone Number: ( ) _____-_____

Counselor: _____

## CONFIDENTIALITY

I place a high value on the confidentiality of the information that clients share. This sheet was prepared to clarify my legal and ethical responsibilities regarding this important issue.

RELEASE OF INFORMATION TO OTHERS: If for some reason there is need to share information in your record with someone not employed here (physician, family member), you will first be asked to sign a "Release of Information" authorizing your counselor to transfer the information.

EXCEPTIONS TO CONFIDENTIALITY: There are several important instances when confidential information may be released to others WITHOUT your permission.

1. IF YOU THREATEN TO HARM YOURSELF OR SOMEONE ELSE and your threat is believed to be serious, I am obligated under the law to take whatever actions seem necessary to protect you or others from harm.

2. If we have reason to believe that you are ABUSING OR NEGLECTING A CHILD OR ELDERLY PERSON, I am obligated by law to report this to an appropriate state agency. This law also applies if you report that you have reason to believe ANOTHER PERSON is abusing or neglecting the same.

3. If you have been REFERRED TO THIS AGENCY BY THE COURT (Court Ordered) you can assume that the court wishes to receive some type of report or evaluation.

4. If you are INVOLVED IN LITIGATION OF ANY KIND and you inform the court of the services that you received from us (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waiving your right to keep your records confidential.

In summary, I make every effort to safeguard the personal information which you share with me. However, there are exceptions listed above which are mandated by law and I want you to be fully aware of them BEFORE counseling begins. Your signature below lets us know you have read this and understand.

____/____/_____ _____

Date Client's Signature

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## Initial Contract Form

Thank you for selecting Columbia Northeast Counseling Services, LLC for your therapy and/or evaluation needs. So that we may prevent any misunderstanding regarding our policies, we request that you read and sign this explanation of our policies.

**Appointments:**

- All new patients will have new patient forms that need to be completed. There are two means to accomplish this; 1) show up 20 minutes prior to their appointment (the website is www.colanecounseling.com), or 2) print out the required paperwork from the website and come in five minutes early.
- From time to time schedules can change and we understand. Please call our office 24 hours in advance to let us know if you need to cancel or reschedule your appointment or you may be charged for the visit. The charge for a late cancel, late reschedule, or no show is half of the full fee charged for a visit.
- Three missed consecutive appointments may terminate the counseling relationship.
- If you show up late to your appointment, the appointment may be subject to cancellation.
- If, for any reason, the counselor must cancel an appointment, the patient will be advised at the earliest possible time and will not incur any financial penalty.

**Medical Information:**

- Form fees such as FMLA, Life Insurance, and other forms will be assessed $50.00 per form.
- Letters from your provider on the Medical Practice letterhead will be made available at a cost of $50.00.
- It is agreed that any of the counselors in the office may see the notes of the patient if involved in the case of an emergency of patient care.
- I agree I have read and understand the HIPAA Notice of Privacy Practices.

**Emergencies/After Hours**

- If you are having a life threatening medical or mental health emergency then first utilize the emergency resources that are available through the local emergency room or you should call 911.
- If you are having a non-life threatening urgent issue, then during normal business hours, the receptionist will facilitate setting up an emergent/urgent contact.

**Payment Policy**

- The client is responsible for payments at the time services are rendered. All co-payments are due at the time of service. Columbia Northeast Counseling Services, LLC accepts cash, personal checks, MasterCard, and Visa. A $25.00 service charge will be assessed for returned checks.
- Exceptions to the above payment policy will be dealt with on a case-by-case basis.
- Presenting your insurance card(s) will allow us to verify whether or not your insurance carrier is one with which we routinely file claims. Failure to present all insurance information at the time of service (primary, secondary, and EAP) may result in the loss of your benefit.
- Any problem with your insurance carrier that delays or prevents payment of claims is the client's responsibility.

**I have read the above policies, understand, and agree with them.**

_____ _____

**Patient's Signature** **Date**

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## Medical History

Patient Name: _____

Family Doctor (PCP): _____

Have there been any changes in your health since your last appointment?
☐No ☐Yes
If yes, please describe:
_____

Are you taking any medications, including over-the-counter medications?
☐No ☐Yes
If yes, please specify name and dosage:
_____
_____

Do you have any problems with your health (e.g. digestive problems, chronic pain)?
☐No ☐Yes
If yes, please specify:

---

Do you now or have you ever had any of the following? (Check all that apply)

☐Unusual habits
☐Nervousness/panic
☐Asthma
☐Seizures or convulsions
☐Heart conditions
☐Substance use
☐Caffeine use
☐Diabetes
☐Significant physical injury/trauma
☐Sleep problems
☐Eating problems
☐Hearing problems
☐Vision problems
☐Memory problems
☐Anemia
☐High blood pressure
☐Tobacco use
☐Chronic headaches
☐Arthritis
☐Bleeding problems
☐Tics
☐Other: _____

Please chose those illnesses which have been present in family members. Please list the

family member.

| | |
|---|---|
| ☐Allergies | ☐Asthma |
| ☐Seizures | ☐Neurological problems |
| ☐Diabetes | ☐High blood pressure |
| ☐Schizophrenia | ☐Anorexia/Bulimia |
| ☐Depression | ☐Obsessive-compulsive disorder |

Please rate how your problem(s) or emotional status are currently functioning in the following areas.

Family Relations: ☐None ☐Mild ☐Moderate ☐Severe
Work/School Performance: ☐None ☐Mild ☐Moderate ☐Severe
Social Relations: ☐None ☐Mild ☐Moderate ☐Severe

_____ _____

Signature of Patient Date

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## Self-Assessment

Name:_____

What is happening in your life which resulted in this appointment?

_____

_____

_____

What would you like to see accomplished in therapy?

_____

_____

_____

Chief Complaints (Check all that apply to you)

☐Depression
☐Low energy
☐Low self-esteem
☐Poor concentration
☐Hopelessness
☐Worthlessness
☐Guilt
☐Lose track of time
☐Unpleasant thoughts
☐Anger/Frustration
☐Easily agitated/annoyed
☐Defies rules
☐Blames others
☐Argues
☐Excessive use of drugs
☐Chest pain
☐Trembling/Shaking
☐Blackouts
☐Tingling/Numbness
☐Fear of dying
☐Thoughts racing
☐Cannot hold onto an idea
☐Excessive behavior
☐Delusions/Hallucinations
☐Not thinking clearly
☐Feeling that you are not real
☐Sleep disturbance (More/Less)
☐Appetite disturbance (More/Less)
☐Thoughts of hurting self
☐Isolation
☐Sadness
☐Stress
☐Anxiety/panic
☐Heart pounding/racing
☐Excessive use of alcohol
☐Excessive use of prescription medications
☐Sweating
☐Chills/Flashes
☐Physical abuse issues
☐Sexual abuse issues

☐Nausea ☐Spousal abuse issues
☐Phobias ☐Obsessions/compulsive behavior
☐Other: _____

Previous outpatient therapy? ☐No ☐Yes, with _____
When? _____
What was accomplished? _____

Previous hospitalization for mental health treatment? ☐No ☐Yes
When? _____
Where? _____
Treatment: _____

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## Credit Card Payment Authorization Form

I have provided Suzanne W. Peebles, M.Ed., LPC with my credit card number and authorize her office to keep my signature on file, and to charge my credit card account (designated below) for all services, to include any sessions, any missed appointments, any balances, and for all third party payments paid directly to me, that were due to Suzanne W. Peebles, M.Ed., LPC.

I understand that this form is valid unless I cancel the authorization through written notice and that an invoice for all paid balances will be provided to the authorized cardholder, only upon direct request to the counselor.

Name on Credit Card: _____
(If a third party is the financially responsible party, client must provide a Release of Client Information Authorization).

Type of Card: ☐Visa ☐MasterCard (No AMEX or DISCOVER accepted)

Credit Card Number: _____

CVS #:_____ Expiration Date: _____
3 digit Security Code on back of card as provided on card

Cardholder's billing address and zip code:

_____

_____

_____

By signing this agreement, I assume sole responsibility for all unpaid balances; all unpaid balances must be paid in full before scheduling future sessions with a counselor.

_____ _____
Cardholder's Signature Date

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

| 1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY SEX M F | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
|---|---|---|
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | 7. INSURED'S ADDRESS (No., Street) |
| CITY / STATE | 8. RESERVED FOR NUCC USE | CITY / STATE |
| ZIP CODE / TELEPHONE (Include Area Code) ( ) | | ZIP CODE / TELEPHONE (Include Area Code) ( ) |

| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
|---|---|---|
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) YES NO | a. INSURED'S DATE OF BIRTH MM DD YY SEX M F |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? YES NO PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC) | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d. |

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | 15. OTHER DATE QUAL. MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
|---|---|---|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a / 17b NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER |

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | NPI | |
| 2 | | | | | | | | NPI | |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. Rsvd for NUCC Use |
|---|---|---|---|---|---|
| | | | | | |

| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION a. b. | 33. BILLING PROVIDER INFO & PH # ( ) a. b. |
|---|---|---|

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER