333 Margie Dr. Ste. C Phone: 478-449-1475
Warner Robins, GA 31088 Fax: 877-712-4794

Information Pertaining to Client:

Clients Full Name:_____**Preferred Name:**_____

Clients DOB:_____ **Sex:** ( )M ( )F **Marital Status:**_____

SSN:_____ **Employment Status:** Employed/Unemployed/Student
(Circle One)

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Primary Phone:_____May we leave a message here: ( )Y ( )N
Please indicate: ( )Cell ( )Home ( )Work

Secondary Phone:_____ May we leave a message here: ( )Y ( )N
Please indicate: ( )Cell ( )Home ( )Work

Email:_____

Emergency Contact Info: Name:_____**Phone Number:**_____
Relationship to Patient/Guardian:_____

Ok to release information to the Primary Care Doctor: ( )Yes ( )No
If yes, what is the Primary Care Doctors Name/Practice Name:_____

How did you hear about us?_____
Examples: Doctors Office (which), Online (Psychology Today, Website, Facebook), Flier at a location

Parent/Legal Guardian Information (for clients under 18):

Full Name:_____DOB:_____

Address if different then listed above:_____

Phone Number if different then listed above:_____
Please indicate: ( )Cell ( )Home ( )Work

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**

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Insurance Information:

Primary Insurance Name and Phone Number:_____

Name of Insured:_____ DOB of Insured:_____

Relation to Patient:_____

Insureds ID Number_____Group Number_____

Secondary Insurance Name and Phone Number:_____

Name of Insured:_____ DOB of Insured:_____

Relation to Patient:_____

Insureds ID Number_____Group Number_____

Tertiary Insurance Name and Phone Numer:_____

Name of Insured:_____ DOB of Insured:_____

Relation to Patient:_____

Insureds ID Number_____Group Number_____

I hereby authorize Southern Bridge to furnish my insurance company with any requested information concerning my present treatment. I understand that I am financially responsible to Southern Bridge for all charges not covered by my insurance.

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**

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Authorization to Release Information:

This form, when completed and signed by you, authorizes me to release protected health information from your clinical record to the person you designate.

I,_____(print name) authorize Southern Bridge to release/retrieve any notes and/or treatment plans and/or other information regarding the patient to/from:

_____

(If you do not want anything released to anyone please indicate that on this line)

You have the right to revoke this authorization in writing at any time by sending the written notification to the office address listed above.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by HIPAA Privacy Rule.

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**

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CONSENT TO TREATMENT/SERVICES

I hereby request and consent to services for myself/dependent which includes therapy, consultation, case coordination, and other treatment/services recommended and considered necessary by Southern Bridge. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist. Per this consent form, patient/guardian is being informed that there is a possibility that an experienced Behavioral Health Intern under supervision will provide treatment. Clients have the right to choose which professional they use.

I am aware that I may stop treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems If I stop treatment. (for example, if my treatment has been court ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and services I receive. I have been informed that any information regarding services at Southern Bridge are subject to release only by my informed and written consent or by subpoena and/or court order.

I have been informed that any information regarding services at Southern Bridge are subject to release only by my informed and written consent or by subpoena and/or court order.

I authorize Southern Bridge to release any medical information necessary to process claims for the services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**

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CANCELLATION/FINANCIAL/COURT POLICIES

CANCELLATION POLICY: We look forward to working with you. Our appointment sessions are approximately 60 minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 15 minutes late, we will have no choice but to reschedule your appointment and you will be responsible for the fees of a no show. In order to avoid paying no show fees, we require at least a 24 hour notice for all cancellations, unless your appointment is on Monday, at which cancellation needs to be before 12pm on the prior Friday. Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for the $30.00 fee for a missed appointment or late cancellation. After 2 late cancellations or no shows you will not be able to reschedule another appointment without consent of the therapist and at that time it will be decided on whether or not we will discontinue service with you and refer you to another provider.

Check Policy: Check payments are to be made out to Southern Bridge. Please note there is a $35.00 charge for any returned checks.

FINANCIAL POLICY: Patient agrees that if an open balance goes past 90 days they will be properly notified via letter and no more appointments will be scheduled until balance is paid in full. After 2 letters of being notified of past due balance, the patients account will be turned over to a collection agency.

COURT POLICY: Southern Bridge and its counselors will not go to court unless subpoenaed in which case there will be a fee of $150.00 per hour that is required to be paid prior to hearing.

I have read and understand the cancellation policy and the check policy.

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**

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HIPAA ACKNOWLEDGEMENT

I understand that I have the right to review Southern Bridge Notice of Privacy Practices prior to signing this consent. I understand that Southern Bridge reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I, _____, have been furnished with a copy of this office's Notice of Privacy Practices.

Client Name (Printed) **Client or Parent/Legal Guardian Signature** **Date**