Transformative
Counseling & Family Services

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TransformativeCFS.com

New Patient Information

Patient Last Name	**Patient First Name**	**Middle Initial**
Pronouns (circle one) He/Him She/Her They/Them		**Date of Birth (mm/dd/yy):**
Address	City, State, Zip	
Guardian **(First, Middle Initial & Last name):**	**Patient SSN#**	
Home Phone#	**Cell#**	**Email:**

Insurance Information Please provide a copy of your insurance card and identification	
Name of Responsible Party for Account	Relationship to patient
Date of Birth for Responsible Party	Address of Responsible Party
SSN# for Responsible Party	City, State Zip
Primary Insurance:	
Name of Insurance	
Policy #	Group #
Employer name:	Work phone #
Policy Holder Name:	Policy Holder Date of Birth:
Policy Holder SSN #	Relationship to Patient:
Policy Holder Address:	

Secondary Insurance:	
Name of Insurance	
Policy #	Group #
Employer name:	Work phone #
Policy Holder Name:	Policy Holder Date of Birth:
Policy Holder SSN #	Relationship to Patient:
Policy Holder Address:	

Emergencies/Crisis
If you are in crisis or have an emergency please adhere to the following:

- For medical emergencies, call 911.
- For mental health emergencies or crisis, contact the Crisis Line at 206-461-3222. The Crisis Line will direct you appropriately and help you manage the crisis. After the crisis, please make an appointment to see your therapist as soon as possible.

_____ (initials)

Emergency Contact
In the event of an emergency while in my office, below are the people who can be contacted.

Contact # 1	**Contact # 2**
Name:	Name:
Phone #	Phone #
Relationship to client:	Relationship to client:

Electronic Communication Policy

With the increased use and advances in technology, communication styles have changed to include communicating by email, text or instant messaging. My preferred method of communication is by phone. Although I am not opposed to communicating by other means, it is important to note that other communications cannot guarantee your confidentially or privacy.

Emails, text or instant messages should not be used for emergency communication. When having a crisis or emergency, please contact 911 or the Crisis clinic at 206-431-3222.

Please note that you may not be contacted immediately. If you are comfortable with additional forms of communication other than phone calls, please list the preferred method below. Please initial that you have read this passage about Electronic Communication.

_____ (initials)

Preferred or other methods of communication:

Email: _____

Cell: _____

Policies and Procedures

The following is the statement of our financial policy, which we require that you read and agree to prior to any treatment.

Insurance copayment or full payment (if Private Pay) is due at the time of service. If either of these amounts is not received at the time of service, you may be denied services**.**

We will bill your insurance as a courtesy whenever applicable; however, it is important to understand that we are not responsible for the collection of your insurance payment(s). Co-pays are due at time of services. Any balances not collected at time of service will be collected by our office staff. Finance charges may apply to balances that are over 120 days old. Your account may be sent to collections if we do not receive payment for balances over 120 days old and have not been contacted by you to set up a payment plan.

Our billing is managed by Accurate Medical Billing, LLC. You may receive statements or be contacted by them should you have balances. They may also contact you to obtain current and accurate information in order to have claims processed correctly by your insurance.

In the event that your insurance company declines to make payment on your claim, then you are ultimately responsible for the payment of your account in full.

It is your responsibility to know your own insurance benefits, including whether your clinician is a contracted provider with your insurance company, your covered benefits (and any exclusions in your insurance policy), and any pre-authorization requirements of your insurance plan.

Please confirm your insurance policy coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any periodic updates or changes in coverage. Should you fail to provide this information, you will be financially responsible for any balance on the account.

Claims denied due to lack of coverage or eligibility will be transferred to patient responsibility at the private pay rate.

Some insurance coverages have out-of-network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services as part of an out-of-network benefit, your portion of the financial responsibility may be higher than the in-network rate.

It is important to be on time for your appointment as it cannot be extended beyond the scheduled time allotment. If you are unable to keep your appointment, please contact your clinician at least one business day in advance. **If you are unable to provide one business day notice, you will be charged your hourly rate fee.** Please note that insurance plans and health benefit cards cannot be used for payment for missed appointments and any No-Show or Late Cancel fees will need to be billed directly to you.

Should you request a clinician to complete a legal/school/or other document or form, you will be billed your hourly rate in increments of 15 minutes. Depending on the complexity of the document and timeframe for completion, there may be additional fees. In some instances, you may be requested to schedule an appointment with your clinician to assist in the accurate completion of the document. Payment for the completion of any document or form is due prior to the clinician beginning any work.

We do not recommend having your clinician testify in court. However, should your records be subpoenaed, we are obligated by law to release your records. Should you request your clinician to testify in court, you will be billed the standard hourly rate for your clinician to attend.

Please sign below that you have read and understand the above information contained in the Patient Information and Polices Form.

_____ **PRINTED CLIENT NAME**

_____ _____

CLIENT/GUARDIAN SIGNATURE **DATE**

Thank you for choosing Transformative Counseling & Family Services. We look forward to working with you and your loved ones.