LIFE CONNECTION COUNSELING

Transforming Lives, Connecting Marriages & Families

IMPORTANT INFORMATION FOR CLIENTS

Welcome to Life Connection Counseling. Please read the following information and bring any questions you might have to our attention.

Fee – The fee for a 60 minute session is $190. We request payment for all services be made at the time services are rendered. It is the policy of this office to turn delinquent accounts over to a collection agency. Only information which is non-clinical in nature will be given to the collection agency for this purpose.

Telephone Calls – Our office is open Monday through Friday from 8:00 a.m. – 5:00 p.m. After hours you may leave a message on our voice mail. In the case of an emergency or life threatening event, please call 911.

Appointments – When you make an appointment, a specific time is reserved for you. If you are late to your appointment, you will be seen for the remaining portion of your reserved time. Clients can schedule future appointments with the office assistant at the front desk, or through our online portal.

If you must cancel an appointment, please do so at least 24 hours in advance. If not, you will be charged $190.00 for the full session.

Insurance – Services in this office may be covered by medical insurance plans. However, few policies cover 100% of the cost. If you request, the office staff will assist you with insurance filing, but collection of insurance claims is ultimately the insured client's responsibility, regardless of your in network or out of network benefits. **Please understand you are fully responsible for the payment of all fees for services provided, regardless of the extent of any insurance coverage you may have**. If the therapist is not in network with the client's insurance company, it is not our policy to accept any reduced rate the insurance company may offer. Please notify LCC of any personal address change or changes in insurance coverage.

Confidentiality – All information you reveal to your therapist is confidential and will not be released to any outside person or agency without your written authorization. When more than one family member is seen during a session, each of these legally competent individuals must sign a consent form. There are several limitations to this which include: 1) if, in the therapist's opinion, revealing the information would be necessary to prevent a person's death or serious injury, 2) insurance company requests for a diagnosis and general description of services rendered, and 3) other circumstances where it is legally required, such as the physical or sexual abuse of a minor.

I have read the above policies, and understand my responsible for any unpaid balance on my account.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, you must read and sign this consent form stating you understand and agree with the manner in which your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE available at the front desk before signing this consent.

1. The client agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured this office will limit the release of all PHI to the minimum needed to satisfy insurance company requirements.

2. The client has the right to examine and obtain a copy of the information they have provided to us, and request any corrections or updates. The patient may request information regarding disclosures and submit to us in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.

3. A client's written consent need only be obtained one time for all subsequent care given the client in this office.

4. The client may provide a written request to revoke consent regarding release of information at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request was presented.

5. For your security and right to privacy, all staff has been trained in the area of client record privacy. We have taken all precautions known by this office to assure your records are secure.

6. If the client refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact LCC at 918-496-9588

Date: _____

LIFE CONNECTION COUNSELING

CLIENT

Last Name _____ First Name _____ MI_____

Address _____ City, State _____ Zip _____

Date of Birth _____ Age _____ Social Security#_____

Employer _____ Occupation _____

Highest Education Completed _____ Church Affiliation _____

Phone: Home _____Work _____ Cell _____

Contact me by: Home Number ☐ Work Number ☐ Cell Number ☐

Email_____ May we contact you via email: Yes ☐ No ☐

SPOUSE/PARENT/GUARDIAN

Last Name _____ First Name _____ MI _____

Address _____City, State _____Zip _____

Date of Birth _____ Age _____ Social Security # _____

Employer _____ Occupation _____

Highest Education Completed _____ Church Affiliation _____

Phone: Home _____ Work _____ Cell _____

Email:_____ May we contact you via email: Yes ☐ No ☐

INSURANCE PROVIDER: In order for us to verify your insurance, we will need a photo copy of your insurance card and driver's license. We will not file your insurance without them.

Insurance Co.

Name: _____ Policy/Group# _____

Owner of Policy: _____ ID# _____

Address of Insurance Co. _____Phone # _____

****Please note that we file insurance as a courtesy. You will ultimately be responsible for your account and whatever they do not cover according to our charges****

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Marital Status

☐ Single, Never Married
☐ Single, Widowed
☐ Single, Divorced
☐ First Marriage
(How Long :_____)

☐ Married, Separated)
☐ Remarried
(How Long :_____)

Please Circle:

Husband's: 1st, 2nd, 3rd, 4th Wife's: 1st, 2nd, 3rd, 4th

Emergency Contact person (other than household member**)**

Name:_____ Relationship:_____

Address:_____City:_____ State: _____ ip:`

_____

Phone: Home:_____ Wor:A _____ Cell: _____

Additional Family Members (List all children by any marriages whether living at home or not)

	Name	Sex	Age	DOB	Education	Occupation	Living @ Home?
Child							
Child							
Child							
Child							
Child							

Anyone Else Ever Living In The Home

_____:____:_____:_____:_____:_____:_____:_____

Please list any recent stressful events or changes which have occurred in the last year (deaths of friends or relatives, marriages, divorces, changes in work, school, residence, church, etc.).

_____
_____
_____
_____

Medical History:

Family Member	List Any Recent Illness, Tests, or Hospitalizations	List All Medications Taken	Physician

Who referred you here? _____

Have you been in counseling/therapy previously? _____

When? _____ By Whom? _____ How Long? _____

In what way would you like the counselor/therapist to assist you?

_____
_____

Do you consider Christian Faith to be an important resource? ☐ yes ☐ no

LIFE CONNECTION COUNSELING

Credit Card Guarantee Form

☐ UNINSURED CLIENTS

Clients who are uninsured or whose insurance does not cover the cost of mental health counseling, because of high deductibles or either limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

☐ INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out of pocket expense to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, that you are responsible for payment. On Day 60, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payment made on these claims thereafter will be immediately refunded to you.

I agree to the above terms and authorize Life Connection Counseling to charge any payment not paid by the end of the week to the above card.

_____ _____

SIGNATURE DATE

CREDIT CARD: ☐ AMEX ☐ VISA ☐ MC ☐ DISC

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS TO RECEIVE RECEIPTS _____

CARDNUMBER _____

EXP DATE _____ THREE DIGIT CID NUMBER: _____