CHILD'S INFORMATION SHEET

Date _____

Child's Name _____ M__ F__ SSN _____ Age_____
First Middle Last

Home Address _____ City _____ State ___ Zip _____

Home Phone _____ Place of Birth _____ Birthdate _____

Religion: __Am Baptist __Baptist __Brethern __Catholic __Church of Christ __Disciples __Episcopal __Jewish __LDS __Lutheran
__Mennonite __Methodist __Presbyterian __UCC __Unitarian __Other _____ __no preference
Name of Home Church/Congregation _____ Pastor/Leader _____

Mother or Guardian _____ Biological ___ Step ___ Adoptive ___ Foster ___

Address (if different) _____ City _____ State _____ Zip _____

Home ph _____ Work ph _____ Cell ph _____

Age _____ Date of Birth _____ SSN _____ Occupation _____

Employer _____ Religion _____

Father or Guardian _____ Biological ___ Step ___ Adoptive ___ Foster ___

Address (if different) _____ City _____ State _____ Zip _____

Home ph _____ Work ph _____ Cell ph _____

Age _____ Date of Birth _____ SSN _____ Occupation _____

Employer _____ Religion _____

List all persons living in the home with the child:

Name _____ Relationship _____ Age _____
Name _____ Relationship _____ Age _____
Name _____ Relationship _____ Age _____
Name _____ Relationship _____ Age _____

Health Insurance:
Primary Insurance: Policy Holder's name: _____

SSN _____ DOB _____ Employer _____

Policy / ID number _____ Co-pay amount _____ Deductible _____

Secondary Insurance: Policy Holder's name: _____

SSN _____ DOB _____ Employer _____

Policy / ID number _____ Co-pay amount _____ Deductible _____

Is Managed Care Pre-Authorization needed? Company name _____

telephone _____ case manager name _____

Medical / Developmental History

Birth weight _____ Problems with birth / delivery? _____
Age walked _____ Talked well _____ Toilet Trained _____
Childhood diseases / Health problems? _____
Allergies? _____
Current weight _____ height _____ Recent weight loss? _____

Medications:
Name _____ dose/day _____ physician _____
Name _____ dose/day _____ physician _____

Cigarettes? ___ No ___ Yes _____ packs per day Average hours of sleep per night? _____
Alcohol? ___ No ___ Yes age of first use _____ typical use pattern _____
Drugs? ___ No ___ Yes age of first use _____ typical use pattern _____

Prior counseling / therapy / substance abuse treatment?

Prior counseling / therapy / substance abuse treatment for family members?

Educational and Social History:

School _____ Grade _____ Teacher _____
Most recent grades _____ Special Education? _____ Behavior Problems? _____

Childhood abuse or history of trauma?

Interests and hobbies?

Friendship / social problems?

Describe the problem or issue that brings this child to evaluation or treatment:

Signed _____ Relationship to Child _____ Date _____

Counseling & Mediation Center, Inc.

NOTICE OF PRIVACY

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996 and enacted in 2003, establishes guidelines for the disclosure of personal health and mental health information to a third party. Information obtained during therapy will not be given to any other person without the written permission of everyone over the age of 18, who have participated in therapy, except as required by the state laws of Kansas.

Under HIPAA legislation, you must also give written permission for me to communicate with you through various ways about appointments and other pertinent information involving your therapy. Please indicate your permission below by *indicating each means of communication* that is acceptable to you.

Yes	*No*	
_____	_____	Mail may be sent to my home address
_____	_____	Mail may be sent to my work address
_____	_____	Phone calls may be made to my home
_____	_____	Messages may be left on my home voice mail
_____	_____	Phone calls may be made to my work. Work number _____
_____	_____	Messages may be left on my work voice mail
_____	_____	Phone calls may be made to my cell phone. Cell number _____
_____	_____	I can be contacted by email. My email address is _____
_____	_____	Information about appointments and other non clinical information may be given to: _____ Relationship: _____

A communication log regarding all information given to anyone other than the individuals participating in therapy is maintained and may be reviewed during a scheduled appointment.

My signature below indicates that I understand my rights to privacy and give permission to Counseling & Mediation Center, Inc. to contact me or others on my behalf through the means of communication identified above.

Client Signature: _____ Date: _____

This is a strictly confidential client mental health record, to be used only by the authorized recipient. Law expressly prohibits re-disclosure, copying, or transfer of the information to any other party.

BUSINESS OFFICE INFORMATION
Counseling & Mediation Center, Inc.

HOURS: Office hours vary, depending on location and clinician. Appointments are usually 45 to 50 minutes in length and are scheduled in advance.

CANCELLATIONS: If you wish to cancel an appointment, please do so at least One business day in advance of the scheduled time. Cancellations made after that deadline will usually be charged at the full fee. If you call after business hours, please leave a message on our office voicemail. Charges for late cancellations are your responsibility, not the responsibility of the insurance company or other third party payment sources.

FEES: All fees, insurance co-pays, and deductibles must be paid at each appointment. Payment options are as follows: cash, check, money order, Visa, or MasterCard. Fees vary by service received. It is your responsibility to determine the co-payment amount; this can usually be done by telephoning your insurance company. If you do not know your co-pay amount, you will be charged an average co-pay of $25.00 per session. Should this amount later be determined to be more or less that the actual co-pay amount, your account will be adjusted accordingly.

USE of HEALTH INSURANCE: Please understand that insurance coverage is an agreement between you and your benefit carrier to pay some of your bill. You are responsible for the payment of your bill regardless of the status of your insurance claim. We will not become involved in disputes between you and your insurance company over payment or in disputes between you and another party over payment of costs. In the case of family therapy, the bill will be in the name of the person carrying the primary insurance benefit.

Under some circumstances (such as court-ordered evaluation or treatment) the treatment may be legally necessary but not medically necessary, and may not be a covered benefit through your insurance. In these situations, patients are required to pay all fees prior to or at the time of the service.

If your insurance company requires preauthorization in order for services to be covered, it is your responsibility to obtain this prior to receiving services. Likewise, if a referral from a primary care physician or lock-in provider is required for your insurance, it is your responsibility to obtain this referral prior to services being provided. Failure to do so may result in a disruption of provided services and we appreciate your cooperation with these issues to help insure continuity of services.

COLLECTIONS: All past due accounts where no effort is being made to pay will be referred to a collection agency.

REFUNDS: If a patient's case is closed or there is no expectation of return, and there is a credit balance, the credit balance will be refunded to the client unless it is less than $5.00. If it is less than $5.00 then it will remain on the account and will be used if the patient returns, or it can be utilized as a donation if requested by the patient.

FINANCIAL CONSENT: I have read the above business office policies and agree to follow these policies and terms as set forth for payment.

_____ _____

Signature of Patient or Parent Date

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

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 ______

PATIENT AND INSURED INFORMATION

↑Sign ↑Date ↑Sign

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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.

PHYSICIAN OR SUPPLIER INFORMATION