Counselor______________

CareNet of North Carolina

CONFIDENTIAL INFORMATION

Chart Number _________

Chart Location _________

Please fill out this confidential information form carefully and completely. This information will be used by your counselor to assist you.

CLIENT INFORMATION

Client Birth date________________ **Age**__________________ **Email address** ______________________

Client Name____
Last First Initial (Jr., Sr., etc.)

Mailing Address____ ____
Street Apt. No. City State **ZIP** **County**

Home phone_________________________ **Work phone** ___________________________**Cell Phone**_____________

CLIENT OR RESPONSIBLE PARTY

Employer____ ______________________
Company Name Your Occupation or Title

____
Address

____ **Email address**:_______________________________
City State ZIP

Party responsible for payment, if other than client:

____
Name

____
Date of Birth

____
Billing Address

____
City State ZIP

____
Phone

Annual Family Income	**Military Status**	**Clergy Status**
less than 10,000	Active Duty	Active
10,000-19,999	Retired	Retired
20,000-29,999	Reserve	Dependent
30,000-39,999	Spouse	Spouse
40,000-49,999	Family Member	
50,000-59,999		
60,000-69,999		
70,000-79,999		
more than 80,000		

Client Sex: Male Female

Marital Status: Single Engaged Married Separated Divorced Widow(er)

Denomination or religious preference________________ **Local church/Congregation** _________________________

Race _________________ **Education** – Circle highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

Personal physician or group practice ____

Current medications ____ Any allergies? ____________________________

In emergency, please notify_____________________________________ Phone ______________Relationship___________

Previous counselor or therapist ____

How did you hear about us? Check all that apply:

Telephone Book	Yellow Pages	Newspaper/Media	Minister	Friend/Family
EAP Referral	Physician	Attorney	Former Client	Newsletter
Radio	TV	Brochure	School System	Web Site
Social Services	Other ______________________________________			Insurance Co.

Would you like to receive free mailings from the center? Yes No

Charges and Payment Information
The charges and payment expectations for services you receive at the center will be established with your counselor at the first session. Payment is expected at the time of service. The center accepts cash, checks, MasterCard, and Visa. Should you have any questions or concerns regarding the charges or payment requirements, please talk with your counselor or the office manager immediately. Faithfulness in the payment of fees becomes an important part of the therapy experience. Payments on account are due upon receipt of the monthly statement. Overdue accounts may result in formal collection procedures.

Cancellations and Missed Appointments
Clients are requested to give a minimum 48-hour notice when cancelling an appointment. Appointments cancelled with less than 24 hours notice or appointments missed without notice are subject to charge. **Unless otherwise specified, this record will be terminated 75 days from the last date of contact with the client.**

Insurance Coverage
The center will assist you in filing for insurance benefits for covered services. If you intend to apply for insurance coverage, please present insurance policy information or a current insurance identification card at the reception area prior to your session. A photocopy of your insurance information will be made to ensure that eligibility of coverage can be verified and that accurate claims can be filed. Please complete the following information **only if you request the center to file your insurance claims.**

Primary Insurance:

Name of Ins. Co.___________________________________

Ins. Co. Phone No._________________________________

Address of Ins. Co._________________________________

Certificate or Policy No.______________________________

Group No.____________ Group Name__________________

Policyholder's Name_________________________________

Policyholder's Birth Date:_____________________________

Policyholder's Soc. Sec.#_____________________________

Patient Relationship to Policyholder:____________________

Secondary Insurance:

Name of Ins. Co.___________________________________

Ins. Co. Phone No._________________________________

Address of Ins. Co._________________________________

Certificate or Policy No.______________________________

Group No.____________ Group Name__________________

Policyholder's Name_________________________________

Policyholder's Birthdate:______________________________

Policyholder's Soc. Sec.#_____________________________

Patient Relationship to Policyholder_____________________

Client Consent:
I have received and read the center's statement of client/patient rights. I have read and understand the center's policy on charges, insurance filing, payment expectations, cancellations, and missed appointments. I agree to and accept financial responsibility for payment for services received. In the event I use insurance benefits to pay all or a portion of the charges, I hereby authorize the release of any medical information necessary to process insurance claims filed on my behalf. I hereby assign payment of insurance benefits to this CareNet counseling center. I acknowledge that I am financially and legally responsible for the full payment of charges for services received in the event my health insurance claims are denied.

X____ ______________________
Patient/Client Date

X____ ______________________
Responsible Party if Other Than Client Date

___________________________________**OFFICE USE ONLY**____

Individual pay or co-pay $________________ Pay $___________ per ____________.

Primary Diagnosis__________________ **Secondary Diagnosis**____________________

Counselor Signature____Date__________________________

Facility____