CareNet Counseling

Counselor_____

CareNet of North Carolina

Chart Number _____

CONFIDENTIAL INFORMATION

Checked Photo ID_____

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

City State ZIP **Email address:**_____

Party responsible for payment, if other than client:

Name

Date of Birth

Billing Address

City State ZIP

Phone

Annual Family Income

- ☐ less than 10,000
- ☐ 10,000-19,999
- ☐ 20,000-29,999
- ☐ 30,000-39,999
- ☐ 40,000-49,999
- ☐ 50,000-59,999
- ☐ 60,000-69,999
- ☐ 70,000-79,999
- ☐ more than 80,000

Military Status

- ☐ Active Duty
- ☐ Retired
- ☐ Reserve
- ☐ Spouse
- ☐ Family Member

Clergy Status

- ☐ Active
- ☐ Retired
- ☐ Dependent
- ☐ Spouse

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_____

CareNet
Counseling

An affiliate of
Wake Forest Baptist Health

Client Rights

- Right to be treated well and have your privacy respected, and freedom from mental and physical abuse, neglect, exploitation, retaliation or humiliation.
- Right to live as normally as possible while receiving care and treatment.
- Right to culturally competent treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disability or substance abuse .
- Right to a personalized and culturally appropriate service plan that focuses on your goals, needs and abilities, strengths, preferences, and cultural background and needs.
- Right to have this plan in place within 15 days of admission to CareNet Counseling.
- Right to exercise the civil rights available to all citizens unless these rights have been limited by a court of law.
- Right to confidentiality. This means no one has access to your identity or health information without your written permission, except in special situations that are defined in the Notice of Privacy Practices and Consent to Treat.
- Right to services that are best suited for your age, level of need, and cultural background.
- Right to be completely informed in advance of the potential risks and benefits of different service choices.
- Right to be free from unnecessary medication.
- Right to consent to or refuse any service you have been offered unless: (a) in an emergency situation, (b) if service was ordered by the court, (c) you are under 18 years old, and your legally responsible person gives permission, even if you object. Refusal or expression of choice may pertain to service delivery, release of information, concurrent services, and composition of the service delivery team and/or involvement in research projects, if applicable.

By signing below you are confirming you have read and understand the information above.

Client/Guardian Printed Name:_____

Client/Guardian Signature: _____Date:_____

Counselor Signature:_____ Date:_____

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Consent To Treat & Center Information

Purpose

We are grateful that you have chosen CareNet Counseling to assist you in growth and wellness. We also appreciate the trust you place in us, and pledge to cooperatively work with you. During the course of your relationship with us, questions may arise about the center and our procedures. This document is to assist you in understanding some of the more important aspects of our relationship.

Personnel

All CareNet counselors, residents, and interns fall under the leadership of the division of Faith Health (Wake Forest Baptist Health). All staff members provide counseling in accordance with NC state laws pertaining to licensure of counselors and therapists. In addition, counselors are credentialed by their respective professional organizations and are clinically supervised.

Confidentiality

Your counseling, including your records, is treated with the strictest confidentiality. The only exceptions to this are: (1) when matters of harm to yourself or others become known to the counselor, (2) when matters of professional consultation or supervision by your counselor would be needed and/or reasonable, (3) when records of your counselor are subpoenaed through the legal system (4) when records are reviewed by your insurance company (5)when records are reviewed by an accrediting agency. We abide strictly by HIPPA regulations to protect our confidentiality. Any other information will be shared only with your written consent. Please feel free to discuss these important matters with your counselor.

Fees

Our services are primarily supported by client fees. Your counselor will inform you of the current cost per 30, 45 or 60 minute individual session and /or couple or group sessions at the outset of therapy. These rates are based on what is known as "the community standard" and are constant across our state wide network. **All fees, including applicable insurance co-pays and deductibles are due at the time of appointment.** Checks should be made payable to CareNet Counseling. We also accept Visa or MasterCard.
NSF Check Charge: Our office will charge a $25.00 fee for any checks returned as NSF.

We realize that in some cases, persons are unable to pay the full fee. No one will be denied initial consultation because of an inability to pay. There are some subsidy funds for these circumstances, although these funds are limited. If you are unable to pay the full fee, you and your counselor can determine together a fee appropriate to your circumstances, or the number of sessions might be limited. Please note that insurance co-pays cannot be reduced for any reason.

Insurance

If you plan to use insurance, please provide insurance information to your counselor prior to your 1st visit. This is to reduce your chances of having to pay full fee in the first session as many insurance companies require prior authorization for services. You may be asked to communicate with your insurance company if issues arise, and your counselor or billing office staff can assist you with this process. Should your insurance company decline to pay for any services rendered, you will be financially responsible for such charges. Insurance charges not paid within 60 days become the responsibility of the client. We do not file insurance for marital visits.

Account Information

Questions or concerns about accounts (billing and insurance) may be directed to your counselor or to our Account Representative, 336-838-1644.

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Appointments
Return appointments are decided upon by you and your counselor. If circumstances prevent you from meeting an appointment, **please call your counselor at the number provided by him/her** so that the time may be given to someone else. **Please Note: A $95.00 no show/late cancellation fee may be charged to you for missed appointments or appointments cancelled without 24 hour notice. These charges must be paid prior to scheduling future appointments.**

After Hours Emergencies
If you are experiencing an emergency situation **after our regular center hours,** you should call 911 or go to your nearest hospital emergency department. If you are in an emergent situation after normal office hours you should contact **Daymark Crisis Line at 336-838-9936.**

Phone Messages
All counselors will return phone calls in a 48 hour (business day) period. If you have called and have not heard back from your counselor within 48 hours please call back.

Possible Risks of Treatment: The therapy process can be fun and exciting. It can also, at times, be very challenging, difficult, and even painful. As with any significant process of change, there are both benefits and risks associated with the change. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger or frustration, or having difficulties with other people. If you experience such difficulties please speak with your counselor pertaining to such struggles.

Complaint Procedure
If you are dissatisfied with any aspect of your counseling process, please let your counselor know so that it can be resolved. If you think you have been treated unfairly or unethically by your counselor and cannot resolve the problem, you may contact CareNet Inc. at 2000 W. 1st St., Winston Salem, NC 27104 for clarification of client's rights and/or to lodge a complaint.

If you have any other questions about our working relationship please feel free to ask

1. **By signing below you are confirming you have read and understand the information above.**
2. **Gives permission for CareNet staff to seek emergency medical care for me from a hospital or physician.**

Client's Printed Name:_____

Client Signature: _____Date:_____

Legally Responsible Party signature_____Date:_____
(if required)

Counselor's Signature: _____ Date:_____

Notice of Privacy Practices Acknowledgment

The Wake Forest Baptist Health Notice of Privacy Practices states how we may use and release your health information. By signing below, you (or your legal representative) agree that you have been offered the opportunity to review the Wake Forest Baptist Health Notice of Privacy Practices, which has been revised as of July 1, 2016.

Printed Name _____

Signature _____ Date _____

FOR WFBH USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____

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