



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:

Annual Family Income

Military Status

Clergy Status

Name _____

Date of Birth _____

Billing Address _____

City State ZIP

Phone _____

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

Active Duty

Retired

Reserve

Spouse

Family Member

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 _____