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.)* *Preferred name*

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

- ☐ 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: _____

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