A.B.L.E.

115 Pershing Road
Columbia, MO 65203-2145
Phone 260.225.3872 Fax 573.474.5683
www.ABLEWellnessCenter.com

CONFIDENTIAL CLIENT INFORMATION SHEET

(Please Print)

CLIENT INFORMATION

Client's Last Name:	**First:**	**MI:**

SSN:	DOB:	❑Male ❑Female ❑Other
Street Address/PO Box:		
City:	State:	Zip:
Email address(es):		
Home Phone ( ) May we leave a message?	Work Phone ( ) May we leave a message?	Cell Phone ( ) May we leave a message?
How were you referred to A.B.L.E. or your provider?		

FAMILY INFORMATION

RELATIONSHIP STATUS:
❑ Married/Living with Partner ❑Single ❑ Divorced ❑ Widowed ❑ Never Married ❑ Separated
❑ Other (specify):

OTHER PEOPLE IN THE HOME:

Name	DOB	Relationship to Client	Occupation

EDUCATION INFORMATION:

If <u>YOU</u> are being seen today, please complete the following:

Highest grade level completed: 1 2 3 4 5 6 7 8 9 10 11
❑ Completed High School
❑ Some College
❑ Undergraduate Degree
❑ Graduate Degree
❑ Other: _____

If <u>YOUR CHILD</u> is being seen today, please complete the following:

School: _____ Grade: _____

Teacher: _____ Principal: _____ School Counselor: _____

Please remember to give your insurance card to A.B.L.E. to copy

INSURANCE INFORMATION			
Primary Insurance Name:			
Subscriber's Name:		DOB:	SSN #:
Policy ID #:	Group #:		Client's Relationship to Subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other
Secondary Insurance Name:			
Subscriber's Name:		DOB:	SSN #:
Policy ID #:	Group #:		Client's Relationship to Subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to my provider at A.B.L.E. for any services provided to me by that provider. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the provider, the Health Care Financing Administration, my insurance company, or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the provider.

PAYMENT FOR SERVICES RENDERED:

I acknowledge that I have a responsibility of paying my co-pay or paying my co-insurance amount at the time of each service. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by A.B.L.E. and/or my health care insurer if the submitted claims or any part of them are denied or not covered for payment. It is my responsibility to notify A.B.L.E. of any changes in my health care coverage or if I have no insurance. I acknowledge that I am responsible for paying for services. In the event that I am unable to pay in full, I agree to arrange a financial agreement at the time of each service. I'm aware that any unpaid balance over 90 days can be referred to a collection agency. I understand by signing this form I am accepting financial responsibility as explained above for all payment of services received.

By signing this document I acknowledge that I have read, understand, and will comply with its contents.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Date

Rev. 12/17

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Informed Consent for Services

I, _____, hereby give my consent to have A.B.L.E. practitioners provide treatment services to me and/or my family members with the following understandings.

If I am a minor, the following areas have been discussed with me in age appropriate terms with my parent/guardian present.

1. I have read and understand the procedures designed to protect my health information.
2. My rights to confidentiality will be protected except under the ethical and legal limitations that I have discussed with my provider. These may include:
    a. Mandated reporting for suspected child or elder abuse and neglect;
    b. Duty to warn for threatened suicide or homicide;
    c. Court ordered release of records;
    d. Written consent for release of records.
3. Group therapy, family therapy, and couple's therapy involve unique issues related to confidentiality and the treatment process. I understand confidentiality in these types of therapies as I have discussed them with my provider and the other participants.
4. I understand that entry into treatment brings with it the risk of emotional discomfort or distress. I also understand the potential benefits of treatment, such as personal growth or decreased symptoms.
5. I recognize that the practice of behavioral healthcare is not an exact science, and therefore acknowledge that no guarantees have been made or can me made regarding the likelihood of success or a specific outcome of any treatment or test performed by my provider.
6. I understand that my provider and I will determine the length of treatment. I may end counseling/therapy at any time by my own decision, and I may seek the opinion of another provider at any time.
7. I understand that a typical session lasts 45-50 minutes, unless other arrangements are made. I will arrange a session schedule with my provider.
8. I have read and understand the A.B.L.E.'s Financial Policies form.
9. I agree to inform my provider in two days advance when I cannot attend a scheduled appointment. I understand that I will be responsible for payment for any missed appointments that are not re-scheduled or cancelled 48 hours before my session time.
10. I have read and understand the Client Services Agreement which is available in the waiting area and which a copy to take home is available upon request.

_____ _____
Client signature Date

_____ _____
Parent/Legal Representative Date

_____ _____
Witness signature Date

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Easy Pay Informed Consent

Please complete and return this easy pay form to Joshua C. Hulen & Associates for when in person transactions are not an option such as for telehealth, no-shows, account balances not covered by insurance, or when payments are covered by a remote party. Full amounts will be automatically charged to your credit card at the scheduled day of service or once a final balance is determined unless other arrangements are made.

Client Name: _____ DOB: _____

I, _____, authorize Joshua C. Hulen & Associates to keep the credit card listed below/signature on file and to charge my account balance. I understand that this authorization will be valid through the expiration of my credit card, unless I cancel this authorization through written notice.

Responsible Party's Signature:_____ Date: _____

Print Name:_____ Relationship to Client: _____

Witness Signature: _____ Date: _____

Credit Card Information

Please select the type of card: ___Visa ___MasterCard ___Discover ___American Express

Credit Card Number:_____ Exp. Date:_____ CVV#:_____

Name on Card: _____ Zip Code:_____

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FINANCIAL POLICY

Thank you for choosing us as your provider of psychological, educational, or wellness services. The following is a statement of our Financial Policy, which we ask you to read and sign prior to receiving any services.
All clients must complete an intake form and provide any applicable insurance information prior to treatment.

PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD

Each provider is an independent contractor and sets his/her own fees and arranges any payment plans. You will be given advance notice of any fee increases. In certain circumstances, a payment plan can be arranged.

STANDARD (NON MANAGED CARE) INSURANCE

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. As a courtesy, we will bill your insurance company. In order to bill your insurance, we need your insurance information. We accept assignment of insurance benefits in most cases. It may be necessary for you to pay for each session in full until your deductible is met.

MANAGED CARE (INSURANCE PLANS FOR WHOM WE ARE A PARTICIPATING PROVIDER)

All co-payments are due at the time of service. If your plan has a deductible, it is necessary to pay your balance in full until your deductible is met.

Please be aware that many managed care companies cover only a limited number of sessions and some require a physician referral prior to treatment and/or ongoing treatment reviews for authorization of additional sessions. In most cases, all visits to mental health professionals (including other providers and psychiatrists) count toward the allotted number of sessions. Please contact your insurance company for the specifics of your policy, as these will directly impact the extent to which our services are covered. In the event that your insurance coverage changes to a plan where we are not participating providers, the guidelines previously stated regarding standard insurance apply. In the event your benefits run out or expire and you choose to continue treatment, you will need to negotiate a payment plan with your provider.

ALL CLIENTS HAVE ULTIMATE RESPONSIBILITY FOR CHARGES INCURRED DURING TREATMENT, REGARDLESS OF INSURANCE STATUS.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

If you cannot attend a scheduled appointment, you will be expected to call your provider 48 hours in advance to cancel. Any sessions missed or cancelled fewer than 48 hours in advance may be charged a **$25.00** Missed Appointment Fee. Insurance and managed

care companies do not cover missed appointments, and such charges are your responsibility. Please help us better serve you by keeping scheduled appointments.

PAST DUE ACCOUNTS

Payment is expected at the time of service. If you are late on payments and have not made prior arrangements with your provider, a 3% late fee will be added to the amount and an invoice will be sent to you. You will be expected to pay the balance of your account or call to set up a payment plan when you receive that invoice. If necessary, your account may be turned over to a collection agency for collection. Reasonable fees for collection, including collection agency fees as well as court cost incurred for collection, will be your responsibility.

FEE FOR SERVICES

Our hourly fee typically ranges from $80-140 per session, depending on the provider and the services provided. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than a typical 45-50 minute hour. *Other services include report writing, telephone conversations lasting longer than 05 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us*. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we typically charge $175 per hour for preparation and attendance at any legal proceeding.

CLIENTS WHO ARE MINORS

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy for A.B.L.E. I understand and agree to this Financial Policy:

_____ _____

Signature of client or responsible party Date

_____ _____

Witness Signature Date

A.B.L.E.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have been provided access to A.B.L.E.'s Policies and Practices to Protect the Privacy of Client's Health Information and consent to the use or disclosure of my protected health information by A.B.L.E. for the purpose of diagnosing or providing treatment to me, obtaining payment for my mental health care bills, to conduct mental health care operations of A.B.L.E., and as required by law.

I acknowledge my rights as a client of this practice concerning my protected health information. I am aware that A.B.L.E. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. **The Notice of Privacy Practices is in the waiting area for review in its entirety.** I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

If you have any questions about this notice, please contact Privacy Officer at 260-225-3872.

_____ _____
Client signature Date

_____ _____
Parent/Legal Representative Date

_____ _____
Witness signature Date