New England Counseling
57 Exchange Street, Suite 403
Portland, ME 04101

**Client Information Sheet**
**CONFIDENTIAL**

Date: _____ Client Name _____ Email:_____

Street Address_____ City_____ State ___ Zip_____

Date of Birth_____Age _____

Home Phone_____Cell Phone_____

May I call you at home?_____Text?____Leave a message?_____

Gender_____Marital Status/Relationship Status (if applicable)_____

Occupation_____Employer_____

Are you involved in a legal case?____

Family Physician:_____

Psychiatrist or psychiatric nurse practitioner (if applicable):_____

What medications are you taking?_____Past Medications:_____

Have you ever had a drug or alcohol problem?_____

Have you ever had a psychiatric hospitalization?_____

Who referred you to our office?_____

Please describe in brief the reason(s) that you are coming today_____

_____

Anything else that you think might be helpful for me to know_____

Have you had previous counseling? _____Therapist's name:_____

What was helpful about your previous counseling?_____

What was unhelpful about your previous counseling? (if applicable): _____

Please describe 3 goals you have for therapy at this time (optional):

1) _____

2) _____

3) _____

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## Client Service Agreement & Consent to Treatment

I, _____ consent to mental health services. I am aware that the practice of medicine, psychiatry and psychology are not exact sciences and acknowledge that no guarantee has been made to me as to the results of evaluation or treatment, the number of sessions necessary, or the total cost of all services. I authorize The Counseling Associates to bill my medical insurance and to release any information necessary to file a claim with my insurance company, HMO, FAP, or any other agency or individual providing reimbursement services. Your contract with your health insurance company requires that we provide certain information relevant to the services which you receive. We are required to provide a clinical diagnosis and sometimes additional clinical information such as treatment plans, summaries, or copies of your entire Clinical Record. We will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we may provide requested information to your carrier. You always have the right to pay directly for our services yourself to avoid the disclosure of any information to your insurance company (unless prohibited by your insurance contract).

You may revoke this agreement in writing at any time. That revocation will be binding unless our office staff have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have any questions regarding the above, please speak with Dr. McCullough.

## Confidentiality

Please see Maine Notice Form for the Health Insurance Portability and Accountability Act attached. Your signature below serves as an acknowledgement that you have been given access to a copy of and have read the "Maine Notice Form" for the Health Insurance Portability and Accountability Act (HIPPA).

_____ _____
Patient's Signature Date

If the patient is a minor, signature of individual with legal custody of child is required.

_____ _____
Parent or Guardian Signature Date

### Confidentiality Regarding Minors

*Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Privacy in psychotherapy is often crucial to successful progress. Thus, before giving parents any information, the counselor will discuss this with the child, if possible, and do their best to handle any objections he/she may have. If the counselor believes that a child is in danger or is a danger to someone else, they will immediately notify the parents of their concern.*

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## Cancellations and Missed Appointments

Your counseling requires that your counselor reserve a significant amount of time exclusively for your benefit. In the event that your schedule requires you to reschedule or cancel an appointment, we will be happy to do so with **AT LEAST 48 HOURS NOTICE (24 hours minimum).** This procedure allows the opportunity for this time to be available to other clients.

We understand that at some time each of us may experience an emergency or simply forget an appointment. However, following the first failure to cancel at least 24 hours in advance, you will be charged the regular fee for services in the amount of $175 for subsequent failures to cancel without adequate notice. Failure to pay this fee may result in termination of treatment and/or submission to a collections agency. Charges for missed appointments cannot be submitted for health insurance reimbursement. *Please note that if a make-up session is available the same week as the initial appointment, the $175 will be credited and insurance can be billed for the session.*

## Emergencies

Your counselor will make every effort to be available in case of emergency. However, since our practice is for outpatient services only, we cannot guarantee around-the-clock availability. Therefore, in the event of an emergency if you cannot reach your counselor you are instructed to contact 911 or visit the local emergency room.

The undersigned certifies that he/she has read the agreement and understands the foregoing and agrees to abide by its terms.

_____ _____
Patient's Signature Date

_____ _____
If patient is a minor, parent or guardian Signature Date

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## Payment/Billing Policies

Psychotherapy session will be between 40-55 minutes depending upon your insurance plan. Your counselor will spend additional time prior to and after your session making and reviewing notes regarding your treatment plan and progress. Our usual office charge is $200 for the initial session and $175 per session for counseling thereafter.

All fees shall be due and paid at the time the service is rendered. We accept several insurance policies and do all billing on your behalf. We will let you know upfront prior to the first session what your responsibility is per your insurance company. However, if insurance payment is delayed or declined for any reason, you will be held responsible for all amounts not paid for by insurance. Rarely do we see this as an issue.

Telephone calls related to therapy, or calls made in your behalf, along with correspondence regarding case management that last longer than 10 minutes will be billed at the usual hourly rate. In addition, if your managed care plan requires additional paperwork your counselor will complete this additional paperwork as part of the counseling session.

The undersigned certifies that he/she has read the agreement and understands the foregoing and agrees to abide by its terms.

_____ _____

Patient's Signature Date

**Please present with your paperwork: Health Insurance Card and Driver's License**

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## Payment Information by Credit Card

*This will only be used for insurance deductible amounts, copays, or missed session fees. You will be provided with a receipt for tax purposes.*

CC#_____Expiration date_____Type of Card_____

Name of cardholder_____Billing Zip_____CCV code_____

## Credit Card Agreement (Required if Paying by Credit Card)

If you would like fees for services (including any deductible amounts or co-pays) rendered to be billed to your credit card please sign your approval for this below and provide your credit card information to our staff.

I approve all fees for services rendered to be billed to my credit card.

_____

Signature Date