Continuing Hope Counseling LLC

534 10th Ave• P.O. Box 73536 • Fairbanks, Alaska 99707
Phone (907) 451-8208 • Fax (907) 451-8208

Welcome to Continuing Hope Counseling!

We are pleased you have chosen to come to Continuing Hope Counseling (CHC). Our staff looks forward to working with you. CHC is a group practice dedicated to providing the best possible psychological and mental health services to our community. We strongly encourage you to take an active role in your counseling experience, and we're pleased to discuss any questions you may have.

Prior to your first appointment, it is important that you discuss our fee with your insurance company and inquire as to whether they accept your provider's credentials. Ultimately, you are responsible for the fees for services rendered. **(initial ___).**

Our administrative office hours are Monday through Thursday 9:00 a.m. to 5:00 p.m. and Friday 9:00am to 12:00 p.m. In case of an emergency after hours, call 911. The providers at CHC establish their own hours and may be available at times when administrative services are not available. After 5 p.m., the agency is officially closed, and clients attending after-hour appointments or groups must be picked up promptly **(initial ___).**

CHC strives to assist clients to resolve their own problems. We believe that as you and your provider work together to address your concerns, you will develop a sense of self-awareness that will influence your behavior and feelings. As a client, you are in complete control and may end our professional relationship at any point. We will be supportive of that decision. We also have the option of ending our counseling association if we determine it is necessary **(initial ___).**

Therapy appointments are approximately fifty to fifty-five (50-55) minutes **(initial____).** Because the clinicians providing services at CHC often consult with each other to ensure the best treatment approach to therapy, your case may be discussed in staffing. Clients arriving more than fifteen (15) minutes late to appointments will be cancelled or rescheduled **(initial____).** The clinical team will maintain the same level of confidentiality as outlined in our **Notice of Privacy Practices**, which is available on our website and from our Front Office staff. You have been provided a copy of this privacy policy **initial____).** We will keep confidential anything you say to us, with the following exceptions: (1) you sign a release directing us to tell someone else; (2) we determine you are a danger to yourself or others; (3) suspicion of child or vulnerable adult abuse; and/or (4) we are ordered by a court to disclose information **(initial ___).**

CHC assures you that our services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your treatment goals. However, together we will work to achieve the best possible results for you. On occasion and consistent with your approval, services may be provided by a student intern under the direct supervision of a licensed provider **(initial ___).**

By signing this document, you are giving your provider consent to provide mental health services to the identified client. If the client is a minor, your signature confirms your legal authority to sign on behalf of the minor. If you have any questions, feel free to ask. **Please sign and date this form.**

_____

Responsible Signature Date

_____

Counselor/Facilitator Signature Date

Registered in Kareo:

Date: _____

Initials: _____

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Provider: _____

Credentials: _____

Client Registration

All fields on this page must be filled out completely before you begin your appointment:

Name: _____
Last **First** **MI**

Nicknames: _____ **Preferred Pronouns:** _____ **Date of Birth:** _____ **Age:** _____

SSN:_____ **Identified Gender:** _____ **Gender Assigned at Birth**: _____
(for insurance purposes only)

Race / Ethnicity: _____ **Marital Status:** _____

Spouse Name: _____ **Parent/Guardian Name:** _____

Emergency Contact: _____ **Emergency Contact #:** _____

Physical Address: _____

Mailing Address: _____

Home Phone#: _____ **Cell Phone#:** _____**Work Phone #:** _____

Can CHC leave a message at: □ Home □ Cell Phone □ Work □ Other _____

Can CHC send electronic statements? □ Yes □ No

As a courtesy CHC will provide a reminder the day before your appointment. How would you like us to contact you?

Email: _____**Phone #:** _____ **Text #:** _____

Referring Provider / Caseworker:_____
(If Applicable)

All fields on this page must be filled out completely before you begin your appointment:

Insurance Information

Primary Insurance: _____	Secondary Insurance: _____
Address: _____	Address: _____
Phone #: _____	Phone #: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Insured's Name: _____	Insured's Name: _____
Insured's S.S. #: _____	Insured's S.S. #: _____
Relation to Client: _____ DOB: _____	Relation to Client: _____ DOB: _____

Provide any Tertiary Insurance coverage on the back of this form.

I attest this information is true and accurate to the best of my ability. I understand that payment for all treatment received is my responsibility. I hereby authorize the release of any information to my insurance company that is required to process a claim on my behalf including, but not limited to, insurance appeal rights on my behalf. I also hereby authorize my insurance company to remit payment for any medical benefits due directly to Continuing Hope Counseling.

Signature of Responsible Party: _____Date: _____

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Billing Information

Continuing Hope Counseling's billing rate for an initial session is **$360.00**. Sessions thereafter start at **$260.00** per individual session. Our billing rate is based on the reasonable and customary charges billed by other counseling services in the Fairbanks area. Our goals are to (1) assure the highest quality of services and (2) ensure the provision of counseling services to all of those in need.

Continuing Hope Counseling offers a number of options regarding the payment of your bill. Below is a list of third-party billers. If you are in need of special assistance regarding payment of services, **please check the appropriate program below.**

___ Self-Pay: I will pay in full at time of service.

___ Insurance: Please bill my insurance company(s). (If my insurance company does not pay for the entire amount of the cost of services, I understand I am responsible for the remainder of the charge.)

___ TriCare client: Dependents and Active-Duty Service Members require a referral from their PCM and/or medical doctor.

___ State of Alaska: For services requested by the Office of Children's Services or another state agency, a Purchase Authorization must be sent directly to CHC from your case worker. Appointments will be canceled if a proper authorization is not received in time.

___ Division of Vocational Rehabilitation: A Purchase Authorization must be sent directly to CHC from your case worker. Appointments will be canceled if a proper authorization is not received in time.

___ Client Assistance Program: I do not have insurance and will need consideration regarding my bill. (Please see the Front Office staff for further paperwork needed to qualify for assistance. Supporting financial documentation must be supplied before an application will be reviewed.)

___ Other (Please specify)_____

___ Credit Card Payment: Please charge my credit card at the time of service. A credit/debit card on file is required for all tele-health services.

____ VISA ____ MasterCard

Acct.#_____ Exp. Date: _____ 3 Digit Code: _____

I authorize the release of relevant information to my insurance carrier or other provider as required to establish benefits, and I agree to assign those benefits to Continuing Hope Counseling. This authorization is valid unless I revoke it in writing. It may be revoked or renewed as desired by both parties.

Printed Name Signature Date

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Financial Policies

Thank you for choosing Continuing Hope Counseling as your behavioral health care provider. We are committed to providing you with the highest quality care available at competitive prices. To continue this service excellence, it is very important that you follow our Financial Policy, which includes prompt payment of your bill. A clear understanding of the financial responsibility for your care is fundamental to assuring a healthy and professional relationship with our staff.

PATIENT INFORMATION FORM - Please complete the Patient Information Form, which includes demographic, emergency, and insurance information. This will ensure correct billing to your insurance carrier. In the event your insurance changes and you do not notify us of the change in time for us to obtain authorizations or file claims within your insurance company's timely filing deadlines, any unpaid fees will become the subscriber's responsibility **(initial____).**

NEW CLIENTS - All new clients are asked to pay the full amount of their first visit at the time of that visit **(initial____).** Insurance will still be billed, and any overpayment will be applied to future sessions.

INSURANCE PLANS - We accept most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to determine if your policy covers our providers and services. In many cases, insurance companies request preauthorization prior to seeking treatment. It is your responsibility to obtain this preauthorization.

- **United Health Tricare**– Some of our services require a medical doctor referral. This will be requested prior to your scheduled appointment. It must be sent to Continuing Hope Counseling before services take place in order to prevent denial of services and the balance fall due to the client. If you are an Active-Duty service member, you *must* secure an authorization before your first visit **(initial____).**

BENEFITS INTERPRETATION - We will do our best to help you understand and interpret your health care benefits. However, it is ultimately your responsibility to understand which services are covered and which are not under your plan. If you have any questions, please contact your insurance carrier to help you with this process **(initial____).**

FISCAL YEAR DEDUCTIBLES - It is our policy at the start of each insurance plan's fiscal year to collect the full amount billable for your visit at the time of your visit until your deductible has been met **(initial____).** Once verification of having met your deductible is made, you will only need to pay your insurance plan's required co-pay or percentage due.

INSURANCE BILLING - If it is determined that your insurance is one that is accepted by Continuing Hope Counseling, we will, as a courtesy, bill this company for you. If your insurance does not pay for any reason and an appeal is needed, your signature on this *Financial Policy* form serves as a waiver for your insurance company to grant us permission to file one appeal on your behalf **(initial____).**

MULTIPLE INSURANCE COVERAGE - For those with secondary or tertiary insurance coverage, we will bill your primary insurance first. Once payment is received from that primary insurance company, we then will bill your secondary insurance company one time. **(initial____).**

Please remember that insurance is a contract ***between you and your insurance***. We are happy to help as much as we can to ensure payment of your benefits; however, we cannot and will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or what insurance companies refer to as "usual and customary" reductions.

CO-PAYMENT/CO-INSURANCE – After you have met your insurance company's deductible, you must pay all required co-payments or co-insurance payments at the time of your appointment. **(initial____).**

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TELE-HEALTH SERVICES – When requested by the client and clinically indicated, services may be provided via tele-health in lieu of in-person appointments. In the instance of some insurance policies, tele-health benefit may be covered differently. It is your responsibility to check with your insurance company prior to treatment to determine if your policy covers tele-health appointments. **(initial____).**

CANCELLATION POLICY – Continuing Hope Counseling requires 24-hour notice for appointment cancellations. A late fee of up to the total cost of the session may be incurred. Payment of late fees is required before additional appointments are made. **(initial____).**

COURT TESTIMONY– For any employee who must testify in court, Continuing Hope Counseling charges five hundred dollars ($500.00) per hour, for testimony and three hundred and sixty dollars ($360.00) per hour for preparation, with a minimum charge for one hour. **(initial____).**

RETURNED CHECKS – There is a $50.00 charge for *all* returned checks.

BALANCES OWED AFTER INSURANCE HAS PAID – If there is a balance owed after your insurance(s) has paid, you are responsible for payment of this balance **(initial____).** If we know what this balance will be at the time of your appointment, you are expected to pay at that time. Otherwise, we will send you a statement in the mail. Payment is due upon receipt. Continuing Hope Counseling reserves the right to discontinue services to you if your account is more than thirty (30) days past due or to refuse services if payments owed at the time of a scheduled service are not paid. Accounts more than ninety (90) days past due or with undeliverable addresses may be forwarded to a collection agency for recovery.

REFUND REQUESTS – Clients who have a credit on their account and would like that amount refunded to them must complete a *Refund Request Form* available from the Front Office staff. Refunds will be made only if the account stands at a zero balance **(initial____).** If it is determined there are other outstanding balances on your account, the requested refund will be applied to the outstanding balance. You must allow up to thirty (30) days from the time the refund is requested to receive the funds.

ACCOUNT RESPONSIBILITY – It is our policy to bill the insurance subscriber for any balances left on accounts. "Accounts" include services rendered to you, a spouse and/or dependents. If any responsible party fails to make timely payments on their portion of the account, we reserve the right to refuse treatment. If you do not have insurance, you are personally responsible for your own debt, and payment is expected at the time of service. In the case of minor patients with no insurance, the adult accompanying the patient is responsible for payments due at the time of service **(initial____).**

CLIENT ASSISTANCE PROGRAM – Our client assistance program is available to those who qualify. Paperwork for this program may be obtained from our Front Office staff and on our website. Once completed and returned with the supporting financial information, the packet will be reviewed for approval. You will be advised of the amount of financial assistance for which you qualify. That amount will be good for a 3-month period, at which time reapplication will be needed if assistance is still desired.

ELECTRONIC STATEMENTS – Billing statements are provided monthly via email or text message to information provided on the Client Registration form **(initial____).**

NO SUPRISES ACT – The No Surprises Act requires good faith estimates from a convening provider to include any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by a co-provider or co-facility. Anticipated service fees are included on the Billing Information section of this intake packet. For any questions on fees for services, please speak with your provider or Continuing Hope Counseling Staff. **(initial____).**

Printed Name Signature Date

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Background Information

In order for us to serve you better it is extremely helpful if we have some background information regarding your situation. Please answer all questions to the best of your ability.
ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE

NAME: _____
Last **First** **MI**

In your own words, please state the concerns that bring you to counseling: _____

_____
_____
_____
_____
_____
_____

Rate the items with which you are currently having difficulty coping. Circle the word(s) in brackets that best define(s) each statement.

O=None 1=Minor 2=Moderate 3=Significant 4=Serious	
Anxiety [Worry] [Fear] [Panic] [Phobia]	0 1 2 3 4
Depression [Sadness] [Hopelessness] [Helplessness] [Despair]	0 1 2 3 4
Thoughts of [Death] [Suicide]	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Mood Swings	0 1 2 3 4
Memory [Forgetfulness] [Changes]	0 1 2 3 4
Grief over [Death of Loved One] [Major Loss]	0 1 2 3 4
Issues Related to [Pregnancy] [Abortion]	0 1 2 3 4
Abuse [Physical] [Domestic] [Emotional] [Sexual] [Ritual]	0 1 2 3 4
Parent(s) had [Alcohol] [Drug] Problem(s)	0 1 2 3 4
Marital/Partner Problems	0 1 2 3 4
Problems with [Parents] [Family] [Children] [Siblings]	0 1 2 3 4
Sexual [Concerns] [Problems]	0 1 2 3 4
Dependency Problems [Alcohol] [Drugs] [Smoking] [Other]	0 1 2 3 4

Have you ever felt people were watching you? □ Yes □ No
Do you hear voices? □ Yes □ No
Do you see things others do not? □ Yes □ No
Do faces ever seem distorted? □ Yes □ No
Do colors ever seem too bright or dull? □ Yes □ No
Have you ever attempted suicide? □ Yes □ No
Have you ever engaged in self-harm? □ Yes □ No

Current Living Situation: Excellent Good Fair Poor

Current Financial Situation: Excellent Good Fair Poor

Occupation: _____
Military History (if applicable): _____
Legal History (if applicable): _____
Children (if applicable): _____
Describe any cultural issues that contribute to your current problem(s): _____
_____
_____

CHILDHOOD HISTORY

Describe your childhood family experience:

Home Environment. [ ] outstanding [ ] chaotic [ ] normal

Witnessed [ ] physical [ ] verbal [ ] sexual abuse toward others

Experienced [ ] physical [ ] verbal [ ] sexual abuse

Birth order/ Number of siblings: _____

Include any relevant history related to development or special circumstances in childhood: _____
_____

PHYSICAL HEALTH HISTORY

Describe your current physical health: [ ] Good [ ] Fair [ ] Poor

Immunizations: [ ] Current [ ] Not Current [ ] Unknown

Nutritional Health:

Do you experience eating related concerns? □ Yes □ No

[ ] overeating [ ] binge eating [ ] restrictive eating [ ] purging

Sleep Behaviors:

Do you experience sleep related concerns? □ Yes □ No

Average # of hours per sleep a night _____

[ ] hypersomnia [ ] insomnia [ ] nightmares [ ] other sleep problems

SURGERY HISTORY (if applicable)

_____
_____

Please circle all that apply

[ ] Cancer	[ ] Diabetes	[ ] Kidney Disease	[ ] Head Trauma
[ ] Fibromyalgia	[ ] Heart Disease	[ ] High Blood Pressure	[ ] Chest Pain
[ ] Osteoporosis	[ ] Arthritis	[ ] Vision Problems	[ ] Lung Disease
[ ] Dementia	[ ] Lung Disease	[ ] Allergies	[ ] Liver Disease
[ ] Ulcers	[ ] Addictions	[ ] Diabetes	[ ] Body Image Concerns
[ ] Stroke	[ ] Thyroid Problems	[ ] Learning Difficulties	[ ] Neurological Concerns
[ ] STIs	[ ] Behavioral Concerns	[ ] Emotional Problems	[ ] Other Medical Conditions

If you answered yes to any of the above, please specify_____

_____

_____

MENTAL HEALTH HISTORY

Prior Psychological Assessments: _____

_____

Prior outpatient therapy/counseling? □ Yes □ No

Prior inpatient therapy/counseling? □ Yes □ No

If yes, on how many occasions? _____ When? _____

Where? _____

Family history of inpatient treatment for a psychiatric, emotional, or substance use disorder? □ Yes □ No

Previous mental health treatment (use the back of page if necessary)**:**

Provider Name	Purpose	From (Year)	To (Year)

MEDICATION

Current prescribed medication(s) (use the back of page if necessary):

Medication	Dosage	Start Date	Stop Date	Reason	Effective?
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No

List name of primary care physician:

Name: _____ Phone: _____

List name of physician who provides medication management (if any):

Name: _____ Phone: _____

SUBSTANCE USE HISTORY (if applicable)

Prior Use: □ Yes □ No **Current Use:** □ Yes □ No

Substance	Frequency of Use	Amount	Length of Use

Prior Substance abuse treatment with: _____

Longest period of sobriety: _____

Describe any additional special circumstance that you would like to make your provider aware of:

_____

_____

_____