LIFE COACHING and COUNSELING CENTERS

CLIENT INFORMATION FORM

Name of Client: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Male □Female Primary Language:_____ □

Single □ Married □ Separated □ Divorced □ Widowed □ Child

Referral Source: Previous Client □ Physician □ Pastor □ Advertising □

Other □ (please specify) _____

Email Address: _____

Briefly state the nature of the presenting problem: _____

_____

For purposes of coordination of care, please answer the following:

Name of primary care physician: _____

Names of other regularly treating physicians (psychiatrist, counselors, etc.):_____

_____

May we have permission to contact them? Yes □ No □

"That all may have life, life in all its fullness." – John 10:10

lifecoachingandcounseling.net

INFORMED CONSENT FOR COUNSELING and/or COACHING

I give my authorization and consent to receive counseling and/or coaching services at LIFE Coaching & Counseling Centers.

I understand that my right to confidentiality is limited by: 1) Any threat to hurt myself (suicide) or others; 2) A suspicion by my counselor or coach of abuse toward anyone, especially if the client is a minor child or an adult over the age of 65.

I have been informed that my counselor or coach may consult with another counselor or coach at LIFE Coaching & Counseling Centers for the purpose of maximizing my counseling or coaching while maintaining my confidentiality.

I am aware that my counselor's or coach's value system is the result of his or her Christian faith, and I am freely entering into the counseling or coaching relationship with that knowledge.

I am freely choosing to enter counseling and/or coaching, and I understand that I may discontinue these services at any time.

I understand my counseling/coaching fee is $_____ per 45-55 minute session and that extended sessions will incur additional charges pro-rated at the same rate. If I need telephone counseling between sessions (beyond a brief call of 5 minutes), I understand I will be charged at the same rate, pro-rated, according to the time needed.

I understand that my checks for counseling fees need to be made out to James Fry, Jim Fry, or LIFE C&C and that he will submit claims to my insurance company for payment.

I am aware that I will be charged a fee of $50 for any missed session with less than a 24 hour notice, except in the case of an emergency.

REQUIRED: I authorize charges to my credit card for missed appointment fees, telephone counseling, unpaid counseling fees, and fees for cancellation with less than 24 hours' notice. All credit card charges will include a 5% processing fee.

VISA/Mastercard #_____

Name on Card _____

Expiration Date _____ 3 numbers on back _____

Street Number where Credit Card Statement is sent _____ & Zip Code_____

_____ _____

Client or Guardian Date

BILLING INFORMATION

What will be your means of payment? Insurance____ Self-Pay_____
For self-pay, complete Section A. For Insurance, complete section B.

SECTION A

What is the combined yearly income for your household?

___ under $25,000
___ $25,000 - $35,000
___ $35,000 - $45,000
___ $45,000 - $55,000
___ $55,000 - $65,000
___ $65,000 - $75,000
___ $75,000 - $85,000
___ $85,000 - $95,000
___ $95,000 - $105,000
___ $105,000 - $115,000
___ $115,000 - $125,000
___ $125,000 and over

Our fees are on a sliding scale basis, which is determined on the basis of your total household income. A fee of _____ has been mutually agreed upon based on the above information. I agree to notify my therapist in the event my financial situation changes. I also agree that I will pay this fee by cash, check, VISA, or MasterCard at each session. I understand that all credit card charges will include a 5% processing fee. If I so request, a receipt will be given to me for tax purposes.

If I need to receive counseling by telephone between sessions, I agree to pay for the portion of a session used. I will give my counselor-therapist at least 24-hour notice of my need to cancel an appointment unless an emergency is involved, or I will pay a $50.00 charge for the missed appointment.

Other arrangements: _____

_____

_____

_____ _____
Patient or Guardian Date

_____ _____
Counselor/Therapist/Coach Date

SECTION B

Please complete the following with the information of the Insurance Subscriber:

Name of the Subscriber_____

Date of Birth_____ Relationship to Client_____

Address (if different from client)_____

_____

Subscriber's Contact Phone Numbers: Cell_____ Home_____

Subscriber's Employer_____ Job Title _____

Health Insurance Company Name_____

Contract/ID/Policy Number_____ Group Number_____

Social Security Number _____

Any Additional Health Insurance Carrier? If so, please specify:

_____

Co-pay and co-insurance amounts are determined by your individual insurance plan. It is the responsibility of LIFE Coaching and Counseling associates to charge these amounts. The co-pay/co-insurance amount determined by your plan is_____per session.
Yearly deductible amounts as determined by your plan must also be met before insurance will pay and are the responsibility of the client.

Unmet deductible on your plan is _____.
This will be paid incrementally at _____ per session.
Receipts for amounts paid are available upon request.

By signing below, I agree to pay all co-pays, co-insurance, and/or deductible amounts at each session as indicated above. I hereby authorize the release of information necessary to file claims, obtain pre-certification of benefits, or verify limits of coverage by my insurance company. I also agree to assign all insurance benefits to the provider of services and agree to pay the difference between the insurance benefits payment and the total charges. I further agree that if my eligibility for coverage by my insurance company cannot be confirmed at this time, or if I or any member of my family is not eligible for coverage, or my coverage has expired at the time services have been rendered, I hereby take full financial responsibility for payment for any and all services rendered to me or any member of my family. A copy of this signature is as valid as the original.

I have read, understand, and agree to all of the above.

_____ _____
Insured, Client, or Guardian Date

_____ _____
Witness Date