AFFILIATED FAMILY COUNSELORS

Please complete all applicable sections in their entirety. Please print clearly and if you have any questions please let us know.

PATIENT INFORMATION *please complete with patient information only*

Date _____ **Social Security #** _____

Patient Name _____ _____ _____
First Middle Last

Preferred Name _____ **Sex**: M / F **Date of Birth** _____

Marital Status: __ Single __ Married __ Divorced __ Widowed **Preferred Contact Number**: _____

Home Address: _____ _____
Street Apartment, Unit, Number

_____ _____ _____
City State Zip

Email: _____ **Primary Care Physician**: _____

Employer: _____ **Phone**: _____

SPOUSE INFORMATION

Name: _____ _____ **Date of Birth**: _____
First Last

Cell Phone: _____ **Sex**: M / F Social Security #: _____

Employer: _____

PARENT/GUARDIAN INFORMATION (if minor)

Name: _____ _____ **Relation to Patient**: _____
First Last

Date of Birth: _____ **Sex**: M / F **Social Security #**: _____

Home Address: _____ _____
❑ Same as Patient Street Apartment, Unit, Number

_____ _____ _____
City State Zip

Preferred Contact Number: _____

Email: _____ **Employer**: _____

INSURANCE INFORMATION

Primary Insurance

Cardholder's Name: _____ Date of Birth: _____
First Last

Secondary Insurance

Cardholder's Name: _____ Date of Birth: _____
First Last

Emergency Contact We will not share patient protected health information with contacts provided unless authorized by patient.

Name: _____ **Relation to Patient**: _____ **Phone #** _____

How Did You Hear About Us? __ Referral _____ __ Internet Search _____
Name Search Engine

__ Family/Friend _____ __ Phonebook __ Website __ Other _____
Name Please List

I attest that the information provided is true and accurate to the best of my knowledge. I understand that it is my responsibility to notify Affiliated Family Counselors of any changes in patient information and that I am responsible for any chargers that might incur resulting from failure to do so.

_____ _____
Patient / Responsible party Signature Date

FINANCIAL POLICY & INFORMED CONSENT

The therapists and staff at Affiliated Family Counselors are committed to providing the best possible care. It is important to our professional relationship that you understand our fee and payment policies. Please review the following information carefully and sign as indicated. If you have any questions about our fees, our policies or your responsibilities, please let us know.

All patients must complete the **Patient Information Form** prior to seeing our counselors. You are responsible for notifying our office of any patient information changes (i.e. address, name change, insurance change, etc.) Any charges incurred due to the failure to report changes of information are the full responsibility of the patient or responsible party.

Affiliated Family Counselors will file patient insurance claims upon receipt of complete insurance information including a photocopy of the insured's card. We reserve the right not to bill secondary insurance. We cannot bill a third insurance party. AFC will not become involved in disputes between patients and their insurance providers, however we will supply factual information as necessary. You are responsible for the timely payment of your account. This includes, but is not limited to: deductibles, co-payments, non-covered charges, and "usual and customary" charges. You will be notified by your insurance company of all payments made to AFC on your behalf and any non-covered charges or remaining balance on your claim. Please call our billing office to make payment arrangements upon receipt of a patient account statement indicating an unpaid account balance.

AFC will do our best to assist in obtaining reimbursement for flexible spending accounts, however AFC will not become involved in account disputes. At your request, you will receive a receipt for services. In addition, AFC will provide you with a copy of applied account payments, once monthly, per patient request. Any additional reporting will be subject to administrative fees.

If a referral is required for your insurance, it is your responsibility to obtain the referral prior to any appointments. Failure to obtain a referral may result in reduction of benefits and any non-covered charges will become the responsibility of the patient.

Copayments and/or coinsurance are due in full **PRIOR** to being seen by a therapist.

I UNDERSTAND I MAY BE CHARGED FOR ANY MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOUR NOTICE.

Payment in full is due at the time of service unless prior arrangements have been made through the business office. We accept cash, checks, Visa & MasterCard. Any overdue balances may be considered for further collection action.

The charge for a returned check is $30.00, payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount. You may be placed on a "Cash Only" basis following any returned check.

If the patient is a minor, the parent/guardian is responsible for full payment and will receive all billing statements.

Clients under the age of 18, who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy is often crucial to successful progress, particularly with teenagers, we may request that the parents give up access to their child's records. If they agree, we will provide the parents with a summary of the child's treatment when it is completed unless the child is in danger or is a danger to someone else. In this case, we will notify the parents of the situation immediately.

A signed release to treat may be required for unaccompanied minors.

If you become involved in legal proceedings that require a therapist's participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if the therapist is called to testify by another party. Due to the difficulty of legal involvement, AFC therapists have a separate rate for preparation for and attendance at any legal proceeding.

In the event you would like AFC to share your patient record with another provider or physician, a Release of Records Consent must be completed. No patient information will be shared without a signed release on file.