



Faith-Integrated Counseling and Professional Services

Counselor \_\_\_\_\_

CareNet of North Carolina
CONFIDENTIAL INFORMATION

Chart Number \_\_\_\_\_

Please fill out this confidential information form carefully and completely. This information will be used by your counselor to assist you.

Chart Location \_\_\_\_\_

CLIENT INFORMATION

Client Birth date \_\_\_\_\_ Age \_\_\_\_\_ Email address \_\_\_\_\_

Client Name Last First Initial (Jr., Sr., etc.)

Mailing Address Street Apt. No. City State ZIP County

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

CLIENT OR RESPONSIBLE PARTY

Employer Company Name Your Occupation or Title

Address

City State ZIP Email address: \_\_\_\_\_

Party responsible for payment, if other than client:

Annual Family Income

Military Status

Clergy Status

Name

Date of Birth

Billing Address

City State ZIP

Phone

- less than 10,000
10,000-19,999
20,000-29,999
30,000-39,999
40,000-49,999
50,000-59,999
60,000-69,999
70,000-79,999
more than 80,000

- Active Duty
Retired
Reserve
Spouse
Family Member
Active
Retired
Dependent
Spouse

Gender: \_\_\_\_\_

Marital Status: Single Engaged Married Separated Divorced Widow(er)

Denomination or religious preference Local church/Congregation

Race Education - Circle highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

Personal physician or group practice

Current medications Any allergies?

In emergency, please notify Phone Relationship

Previous counselor or therapist

How did you hear about us? Check all that apply:

- Telephone Book Yellow Pages Newspaper/Media Minister Friend/Family
EAP Referral Physician Attorney Former Client Newsletter
Radio TV Brochure School System Web Site
Social Services Other Insurance Co.

Would you like to receive free mailings from the center? Yes No

**Charges and Payment Information**

The charges and payment expectations for services you receive at the center will be established with your counselor at the first session. Payment is expected at the time of service. The center accepts cash, checks, MasterCard, and Visa. Should you have any questions or concerns regarding the charges or payment requirements, please talk with your counselor or the office manager immediately. Faithfulness in the payment of fees becomes an important part of the therapy experience. Payments on account are due upon receipt of the monthly statement. Overdue accounts may result in formal collection procedures.

**Cancellations and Missed Appointments**

Clients are requested to give a minimum 48-hour notice when cancelling an appointment. Appointments cancelled with less than 24 hours notice or appointments missed without notice are subject to charge. **Unless otherwise specified, this record will be terminated 75 days from the last date of contact with the client.**

**Insurance Coverage**

The center will assist you in filing for insurance benefits for covered services. If you intend to apply for insurance coverage, please present insurance policy information or a current insurance identification card at the reception area prior to your session. A photocopy of your insurance information will be made to ensure that eligibility of coverage can be verified and that accurate claims can be filed. Please complete the following information **only if you request the center to file your insurance claims.**

**Primary Insurance:**

Name of Ins. Co. \_\_\_\_\_  
Ins. Co. Phone No. \_\_\_\_\_  
Address of Ins. Co. \_\_\_\_\_  
Certificate or Policy No. \_\_\_\_\_  
Group No. \_\_\_\_\_ Group Name \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_  
Policyholder's Birth Date: \_\_\_\_\_  
Policyholder's Soc. Sec.# \_\_\_\_\_  
Patient Relationship to Policyholder: \_\_\_\_\_

**Secondary Insurance:**

Name of Ins. Co. \_\_\_\_\_  
Ins. Co. Phone No. \_\_\_\_\_  
Address of Ins. Co. \_\_\_\_\_  
Certificate or Policy No. \_\_\_\_\_  
Group No. \_\_\_\_\_ Group Name \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_  
Policyholder's Birthdate: \_\_\_\_\_  
Policyholder's Soc. Sec.# \_\_\_\_\_  
Patient Relationship to Policyholder \_\_\_\_\_

**Client Consent:**

I have received and read the center's statement of client/patient rights. I have read and understand the center's policy on charges, insurance filing, payment expectations, cancellations, and missed appointments. I agree to and accept financial responsibility for payment for services received. In the event I use insurance benefits to pay all or a portion of the charges, I hereby authorize the release of any medical information necessary to process insurance claims filed on my behalf. I hereby assign payment of insurance benefits to this CareNet counseling center. I acknowledge that I am financially and legally responsible for the full payment of charges for services received in the event my health insurance claims are denied.

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient/Client

X \_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party if Other Than Client

**OFFICE USE ONLY**

Individual pay or co-pay \$ \_\_\_\_\_ Pay \$ \_\_\_\_\_ per \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_ Secondary Diagnosis \_\_\_\_\_

Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_

Facility \_\_\_\_\_