NEW PATIENT INFORMATION

Today's Date_____

Patient's Name_____

First *Middle Initial* *Last*

Date of Birth_____ Social Security #_____ Gender ◯ M ◯ F

Address _____

City_____ State_____ Zip_____

Primary phone #_____ Secondary phone # _____

Phone # to confirm appointments_____

Email address to confirm appointments_____

Patient's employer_____ Work phone#_____

Patient's spouse's Name_____ SS#_____

Patient's Spouse's Employer_____

If patient is a minor, please complete the following:

Patient's Father's Name

_____

SS#_____

PH #_____

Employer_____

Patient's Mother's Name

_____

SS#_____

PH #_____

Employer _____

Other Family Members Living in the household:

Name	Age	M/F	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been in counseling before? YES ◯ NO ◯ With whom? _____

How did you hear about our office? _____

Are you currently taking any medications? YES ◯ NO ◯

If yes, what are the names of the medications: _____

Name of the physician who prescribed the medication: _____

In case of an emergency, who should we contact? _____

Phone Number_____

INSURANCE INFORMATION

PLEASE BE INFORMED THAT *TRUE JOY COUNSELING & CONSULTING, PLLC* FILES INSURANCE AS A COURTESY AND IT IS IN NO WAY A GUARANTEE THAT YOUR INSURANCE COMPANY WILL PAY FOR SERVICES RENDERED. ALL CLAIMS ARE SUBJECT TO THE WRITTEN CONDITIONS OF YOUR POLICY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THE ACCOUNT AND ANY FOLLOW-UP NEEDED WITH YOUR INSURANCE CARRIER. YOUR SIGNATURE IS REQUIRED IN ORDER TO FILE INSURANCE AND RECEIVE SERVICES.

PRIMARY

Insurance Company _____

Policy Holder Name:_____ DOB:_____

ID# _____ Group#_____

TRICARE INSURANCE – CHECK ONE:

○ PRIME (ACTIVE DUTY) ○ PRIME (RETIRED) ○ SELECT (ACTIVE DUTY)

○ SELECT (RETIRED) ○ RESERVE SELECT ○ RESERVE RETIRED ○ TRICARE FOR LIFE

SECONDARY

Insurance Company _____

Policy Holder Name:_____ DOB:_____

ID# _____ Group#_____

TRICARE INSURANCE – CHECK ONE:

○ PRIME (ACTIVE DUTY) ○ PRIME (RETIRED) ○ SELECT (ACTIVE DUTY)

○ SELECT (RETIRED) ○ RESERVE SELECT ○ RESERVE RETIRED ○ TRICARE FOR LIFE

I AGREE TO ASSIGN TO *TRUE JOY COUNSELING & CONSULTING, PLLC* ALL INSURANCE BENEFITS NOT TO EXCEED TOTAL CHARGE. I AGREE FOR ANY INFORMATION TO BE RELEASED TO INSURANCE COMPANIES AND/OR SPONSORING AGENCIES FOR THE PURPOSE OF VERIFYING OUTPATIENT AND/OR INPATIENT DIAGNOSIS, TREATMENT, AND OTHER DATA. I HEREBY AGREE TO BE RESPONSIBLE FOR THE COST OF ANY NON-COVERED SERVICES AS NOTIFIED BY A MONTHLY STATEMENT AND MY EXPLANATION OF BENEFITS. I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED AT THE TIME OF SERVICE.

I, THE UNDERSIGNED PARTY, DO HEREBY GIVE MY CONSENT TO THE CONTRACTED PROVIDER OF *TRUE JOY COUNSELING & CONSULTING, PLLC* IN THE CAPACITY OF PSYCHOTHERAPIST, FOR TREATMENT.

Patient's Name _____

Patient's Signature _____ Date _____

Parent/Guardian/Responsible Party Signature_____

LETTER OF UNDERSTANDING & CONSENT TO TREATMENT

1. ***IDENTIFIED PATIENT & PATIENT INFORMATION*** – The identified patient and/or collateral individuals to the identified patient should attend scheduled therapy sessions. The identified patient and/or guardian is responsible for letting the practice know of any changes to information. Please update information as it arises.
2. ***CONFIDENTIALITY*** – Therapy information is usually only released after you have given permission by signing a release form. There may be, however, certain times that we would be required by ethics and law to break confidentiality. Those situations would be (a) when there is an immediate threat of suicide or homicide, (b) when there is suspected or actual abuse and/or neglect of a child, the elderly, and/or an individual with disabilities, and (c) legal court orders to provide information.
3. ***INSURANCE & PATIENT RESPONSIBILITY*** – Insurance, in which providers are in-network, will be filed as a courtesy to you and assignment accepted. However, deductibles and/or co-pays are due at the time of service. Failure to pay could result in being referred to collections, if efforts to collect the balance have failed.
4. ***OFFICE HOURS & PHONE CALLS*** – Our office hours are 9:00 A.M. to 4:00 P.M. Monday through Thursday, and on Fridays from 9:00 A.M. to 12:00 P.M. We are closed for lunch from 12:00 P.M. to 1:00 P.M. If you call our office and get a recording, please leave a message on our confidential voicemail.
5. ***CRISIS & EMERGENCY*** – If you cannot call during our normal business hours and you are in crisis, call the crisis line at 244-9191. In life threatening situations, go to the nearest emergency room for immediate care.
6. ***TELEPHONE CONSULTATIONS*** – Phone consultations with you, your physician and/or other clinicians are not covered by your insurance, are therefore your responsibility, and are charged in 15-minute increments at the rate of $150.00 per hour.
7. ***APPOINTMENTS & CANCELLATIONS*** – In the event you cannot keep your appointment, 24-hour notice is required by calling our office. If you do not cancel your appointment, you will be charged a fee by your clinician. If you have several standing appointments and you miss two consecutive sessions without contacting our office, all future appointments will be cancelled. If keeping your scheduled appointments becomes problematic, you will be asked pre-pay for your sessions and the deposit will be applied towards appointments or other fees owed. We use a computerized appointment reminder system to notify you of appointments, but ultimately you are responsible for maintaining your appointment schedule. Consideration will be given for illness and emergencies.
8. ***OFFICE POLICIES*** – A copy of our office policies and practices are available in each office and posted for your review on our web site, truejoycounseling.com. Please read the policies thoroughly regarding the privacy of your personal health information and other practice guidelines.
9. ***LEGAL PROCEEDINGS*** – Contents and documentation of any individual, joint, and/or family psychotherapy session by the patient or their family member(s) are ***not*** to be used in any divorce, separation, child custody, and/or any other legal proceedings. Patients understand and agree that True Joy Counseling & Consulting clinicians will not participate in any legal proceedings based on information obtained during or concerning psychotherapy.
10. ***TERMINATING TREATMENT*** – You have the right to discontinue therapy at any time. Please let your provider or our office know. If at any point during treatment, your provider assess that therapeutic goals are not being met, you are non-compliant, or you are non-responsive in treatment to manage your care, treatment may be terminated, and you will receive written notification.

WE LOOK FORWARD TO A SUCCESSFUL THERAPEUTIC RELATIONSHIP WITH YOU. WITH YOUR SIGNATURE BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS.

_____ _____

PATIENT NAME PRINTED DATE

_____

PATIENT OR GUARDIAN SIGNATURE