Trinity Counseling Services

Welcome! Thank you for allowing us to be part of your journey.

Client Profile

Please print clearly.

Today's Date _____

First Name _____Last Name_____

Date of Birth _____ Sex: Female/Male/Other: _____ *Please circle one.* Marital Status: Single/Married/Widow *Please circle one.*

Contact Number: _____May we leave a message and/or text? *Please circle one.* Y/N

Street Address _____City_____

State_____ Zip_____

Email Address _____
We will not use your email address for marketing.

Emergency Contact _____Phone No _____

Relationship _____

Payment Information – Please select

Self-Pay (No Insurance)	Employee Assistance Program (EAP)	Medical Insurance Coverage *Please verify your benefits with your insurance company.*
Amount $100.00	Name of EAP Company _____ EAP Phone#_____ Referral #_____ Visits Auth _____ Your Employer? _____	Insurance Company _____ ID# _____ Group #_____ Policy Holder _____ Policy DOB _____ Relationship to policy holder_ _____ Deductible _____ Is it met? Y/N Copay Amount _____

Office Policies

Confidentiality Statement

All information in your treatment is held confidential except for circumstances governed by law. **Florida Statue: 491.0147**

Confidentiality and Privileged Communication — any communication between a therapist and patient is confidential. This secrecy may be waived under the following conditions:

1. When the patient agrees to the waiver, in writing, or, when more than one person in a family is receiving treatment, when each family member agrees to the waiver, in writing.
2. When there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society. Therapist will communicate the information only to the potential victim, appropriate family member, and law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against the therapist.
3. There may be times where the exchange of information and/or teaching opportunities may present themselves between a therapist and student intern involving your case.

Cancellations/Missed Appointments

We recognize in today's busy world it is important to maximize time and meet the demands of daily life. We are committed to seeing our patients on time and respect your time. We do understand challenges do occur and take them under consideration. In the instance of a late cancellation (less than 24 hours) or a failed appointment (no-show/or notice, we have found it necessary to charge the client $100.

Policies

1. Co-payments and fee for services are due at each session or invoices are due upon receipt. An 5% late fee will be applied 30 days after the due date (FL Statue 494.00791). New appointments are not scheduled when there is a $100 + unpaid balance by the client.
2. After 10 minutes lateness (without notification,) the session is not held and rescheduled.
3. Session times are up to 60 minutes.
4. If a check is returned for insufficient funds, there will be an additional charge of $50.00.
5. Credit card processing fees will be applied when using a credit card to pay for services.
6. Additional services such as filling out paperwork, sending out a letter on your behalf or communicating on your behalf is billed at the rate of $100 per hour, (not covered by insurance companies).

7. A good relationship/partnership between the provider and patient is essential for optimal treatment outcomes. We reserve the right to terminate the patient/therapist relationship for non-compliance with the treatment plan, rude, abusive behavior, repeatedly not showing up for appointments and non-payment of services rendered.
8. Court appearances are not customary & are billed at $200 per hour with a three-hour minimum for time and travel.

Consent for Behavioral Health Care – Assignment of Insurance Benefits

1. I authorize the release of any medical or other information necessary to process insurance claims. If applicable, referrals to community agencies maintaining your claim. I authorize the release of any medical or other information necessary to process insurance claims.
2. I recognize and accept any personal responsibility for all balances remaining after payment of benefits. I further agree and guarantee that payment of services will be paid within thirty (30) days of service. Florida law dictates an 18% late fee. Failure to pay may make it necessary to place the account in the hands of a collection agency and/or impose late fees. You will be responsible to pay for the cost of the collection and late fees, which may include additional fees of 35% of the total balance, court costs, collection fees and interest from the date of demand. We will pursue legal action for any unpaid balances.
3. I will notify the office of any change in insurance coverage, address and/or phone number prior to my appointment.
4. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.
5. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

Acknowledgement of Good Faith Estimate (GFE).

I understand the process of GFE and understand I have the right to dispute unaware charges over $400.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, and I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Statement of Understanding

I have read and understand the information and informed consents.

Social Media Policy

Please review your understanding of the use of social media at our office. If you have any questions about anything within this document, we encourage you to ask.

Friending

We cannot accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and respective privacy.

Interacting

Please refrain the use of SMS (mobile phone text messaging containing personal information) or messaging on social networking sites such as Twitter, Facebook, or LinkedIn to us. These sites are not secure, and we may not read these messages in a timely fashion.

Email

Refrain email content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with the office by email, be aware that all emails are retained in your medical file and our Internet service providers.

Email is not set up to guarantee privacy of your personal medical record. If you choose to send information through email, please understand we cannot guarantee your privacy by HIPPA standards.

By signing below, you agree you have read and understand the office polices.

Printed Name: _____*Client, Parent, Guardian, or Legal Rep*

Signature: _____Date: _____