FAMILY FOCUS CHRISTIAN COUNSELING, INC.

CLIENT REGISTRATION FORM

(Please Print) Modified January 2017

Today's date:	Provider #:

CLIENT INFORMATION

Client's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home #: ( ) - Cell#: ( ) -

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

GUARANTOR (PERSON FINANCIALLY RESPONSIBLE)/INSURANCE INFORMATION

(Please give your insurance card to your counselor.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home #: ( ) - Cell#: ( ) -

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Tricare	❑ Aetna	❑ Blue Shield	❑ VA	❑ UBH

❑ MHN	❑ Compsych	❑ Cigna	❑ Magellan	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Member ID#:	Group ID#:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Member ID#:	Group ID#:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Client is responsible for all insurance deductibles, copayments, or balance. The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Family Focus Christian Counseling, Inc. (FFCC). I understand that I am financially responsible for any insurance deductibles, co-pays or any balance on my account. I also authorize FFCC, or insurance company, to release any information required to process my claims.

Signature: _____ Date: _____

SPOUSE OR SIGNIFICANT OTHER			
NAME:	Birth date: / /	Social Security no.: - -	**Relationship to Client** (circle one) Spouse /Mother/ Father/ Sibling/Other (please state):
Street address:			Preferred Phone: ( )
P.O. box:	City:	State:	ZIP Code:

PARENT INFORMATION (IF CLIENT IS A MINOR)			
FATHER:	Birth date: / /	Social Security no.: - -	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:			Home phone :( ) Cell phone no.: ( )
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )
MOTHER:	Birth date: / /	Social Security no.: - -	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:			Home phone #: ( ) Cell phone no.: ( )
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Most used phone no.: ( )	Work phone no.: ( )

CURRENT MEDICATION PRESCRIBED

NAME	DATE PRESCRIBED	TREATMENT REGIMEN	TREATMENT PURPOSE	NOTICED SIDE AFFECTS?

CONSENT TO RELEASE INFORMATION		
Physician's Name:		**Type of Provider:**
Organization (if any):		**Phone : ( )**
Address:		
I hereby consent for Family Focus Christian Counseling, Inc. (FFCC) to contact, obtain, release or exchange information with my Primary Care Physician or other health care provider as noted above regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at FFCC and for 1 (one) year following my last visit unless expressly revoked by me in writing.		Print Client Name: _____ Client's Signature: _____ Dated: _____

Financial Arrangements

Our charges for psychotherapy and counseling are based on current, usual, and customary fees for this area of service. Our current fees are $130 per session. We have agreed that your fee(s) for professional services are $_____ per session and/or $_____ per group session. If you are using insurance, then your fee is $130, which will be billed to your insurance company. You are then responsible for ***ALL*** copays or deductibles that are mandated by your insurance company and policy. Please note that you may receive an invoice from us once we receive an EOB (Explanation of Benefits) from your insurance company letting us know if there are any changes to what they have already communicated to you/FFCC prior to payment. Also, insurance policies may change, so please contact your insurance company with any EOB questions or concerns.

When a balance does exist, a billing statement will be mailed monthly and prompt payment is expected at that time. Additionally, consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee. A **$25 charge is made for any check returned to us as non-payable for any reason.** Accounts over 90 days past due may be sent to collections and additional fees may be applied.

Payment is ***required*** at the time services are rendered either by Cash, Check, or Credit Card. By signing below and providing my credit card information, I authorize FFCC to charge my credit card for session fees in which I do not provide payment in the form of cash or check (unless arrangements have been made with the therapist). Additionally, I authorize charges that equal a full fee for missed appointments not cancelled within the 24 hours advanced notice not showing up for scheduled appointments, returned check fees and amount of check paid, past due amount over 30 days. I understand my credit card will only be used under these circumstances and/or when I have failed to provide payment in another form (i.e. cash or check). This also applies to clients who pay with through insurance.

Name on Credit Card	
Billing Address for Card	
Credit Card Number	
Expiration Date	CS (3 Digit code on back)
Credit Card Type	(Circle One) Visa MasterCard

Print Client's Name	Client's Signature	Date
Print Client's Name	Client's Signature	Date

Consent for Counseling

Information for Clients

Appointments: The time we have scheduled has been set aside exclusively for you. All sessions are 50 minutes unless contracted otherwise. Please be here at least five minutes prior to your counseling appointment. If you are more than 20 minutes late we will not be obligated to see you during that hour, unless you have informed us previously. Appointments that are not cancelled 24 hours in advance will be billed to you at your payment fee (insurance companies do not pay for missed appointments).

Payments: Payment is due at time of counseling. Please accept your responsibility to pay at each session. If this is a hardship, please talk to your counselor for other options. If for some reason your account falls into arrears, we may not be able to see you until your balance is paid. It is best to pay before each session-this way you don't need to take time out of your counseling session to write out a check.

Personal: There are numerous methods of psychological treatment. Counselors at FFCC utilize proven treatment modalities and integrate sound biblical principles into their treatment plan. Please understand that we are sensitive to various religious beliefs and practices and we will respect your personal beliefs throughout your treatment experience.

Confidentiality: Our desire is to keep all that is communicated in counseling confidential. This is generally true. If you are involved with Social Services or other legally mandated counseling, we may be required to inform a Social Worker, Probation Officer or court appointed representative. We also use a billing company (Comprehensive Medical Management) and your personal information is required for outside billing.

Social Media Policy: Licensed professionals, interns, or trainees, who function as psychotherapists at Family Focus Christian Counseling, do not accept friend requests from current or former clients on any social media site. Doing so could compromise client confidentiality or blur the boundaries of the therapeutic relationship.

Clients are not to use public messaging on social media sites to attempt to contact their therapist. This could compromise confidentiality and /or delay receipt of their message.

Communication Policy:

- **By phone:** The best way to reach your therapist is by telephone. Please allow 24-48 hours for a response. Any telephone call between a therapist and client(s) over 10 minutes will incur a fee prorated by the next ¼ of an hour.
- **By email:** The next best way to reach your therapist is by email, however, it may involve delays in your therapist receiving your message as email is often not checked daily. Please note: email is not 100% secure, it remains on both sending and receiving servers.
- **By text:** Texting is the least secure way to reach your therapist. Therefore, please confine use of text messaging to scheduling and cancelling appointments to protect your confidentiality.

Please note that all communication with your therapist may become part of your permanent record.

Client Name	Client's Signature	Date
Client Name	Client's Signature	Date
Therapist Signature	Date	

Patient Record of Disclosures

You may request to receive confidential communications of your protected health information (PHI) from Family Focus Christian Counseling, Inc. therapists by alternative means or at alternative addresses. For example, you may not want your bills to go to your home where a family member might see them. Family Focus Christian Counseling, Inc. therapists cannot ask you the reason for your request, and will accommodate all reasonable requests that you make. If you make a special request, you must give an alternative address or other method of contacting you.

I wish to be contacted in the following manner (check all that applies):

- ☐ Home telephone: ( ) -
  - ☐ Okay to leave a message
  - ☐ Leave call-back number only
- ☐ Work telephone: ( ) -
  - ☐ Okay to leave message
  - ☐ Leave call-back number only
- ☐ Written communication
  - ☐ Okay to mail to my home
  - ☐ Okay to mail to my work/office
- ☐ Cell phone: ( ) -
  - ☐ Okay to leave a message
  - ☐ Leave call-back number only
- ☐ E-mail:

Client's Signature	Print Name	Date
Client's Signature	Print Name	Date
Parent/Guardian (if client is a minor)	Relationship	

CONSENT FOR CONTACT

I agree to have my name placed on a mailing list or email list to receive follow-up contact from Family Focus Christian Counseling, Inc. including, but not limited to, seminars/events, educational information, FFCC updates, etc. I understand that I can revoke this consent at any time. By initialing, I provide my consent.

Initials:_____ Email: _____

If you choose to receive e-mail contact from us, please add FFCC's email address to your contact list, which is info@familyfocuscounseling.org .

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that was given to you. FFCC Notice of Privacy Practices provides information about how Family Focus Christian Counseling, Inc. (FFCC) and their independent therapists may use and disclose your protected health information. FFCC encourages you to read it in full.

FFCC Notice of Privacy Practices is subject to change. If FFCC changes this notice, you may obtain a copy of the revised notice from FFCC by calling (619) 440-4211.

If you have any questions about the Notice of Privacy Practices, please contact your therapist at: 500 Fesler St. Suite 208, El Cajon, California 92021.

I acknowledge receipt of the Notice of Privacy Practices of Family Focus Christian Counseling, Inc.

_____ _____
Client/Parent/Conservator/Guardian Date

_____ _____
Client/Parent/Conservator/Guardian Date

_____ _____
Therapist Date

INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my clients acknowledgment of his or her receipt of FFCC's Notice of Privacy Practices.
However, because of _____ I was unable to obtain my client's acknowledgment.

_____ _____
Signature of Provider Date

RECORD OF DISCLOSURES

INFORMATION BELOW IS TO BE FILLED OUT BY YOUR THERAPIST AS NECESSARY
All disclosures will be made pursuant to the guidelines and requirements as detailed in the "Notice of Privacy Practices". Healthcare entities must keep a record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Date	Disclosed to:	D/C Authorized?	Purpose of Disclosure	By Whom Disclosed	(1)	(2)

(1): Type key: T=Treatment Records; P=Payment Information; S=Dictated Summary; O=Healthcare Operations
(2): Enter how disclosed was made: F=Fax; P=Phone; M=Mail; O=Other

I understand that I may receive a copy of this form after I sign it. A copy of this form has been requested and received: Yes___ No___ Client Initials: _____