Agape Christian Counseling

2124 Crown Centre Drive, Suite 400
Charlotte, NC 28227-7804
704-849-0144

NEW CLIENT APPLICATION

Please complete the following information to better help your counselor assess your situation. The information will be kept confidential. If you are completing this as a parent or guardian of a prospective client please complete the information pertaining to the client.

CLIENT INFORMATION

Today's Date:

Last Name:	First Name:	Date of Birth:
Address:		Apt #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Home E-mail:	Most Recent Employer:	
Highest Grade/Degree Completed:	If not currently Employed check here:	
Name of Emergency Contact:	Cell Phone:	Work or Home Phone:
If age 18 or younger, name(s) of Parent/Guardian/Grantor		

Marital Information

If Applicable, provide information about marriage(s)

Current Marital Status			Current Spouse	Previous Spouse:
Single:		Name:		
Engaged:		Date of Birth:		
Married:		Year Married:		
Separated:		Year Separated:		
Divorced:		Year Divorced:		
Widowed:		Year Widowed:		

Family Information

Is your mother living?	Is your father living?
If you were raised by anyone other than your biological parents, by whom?	

If applicable, please give information about your children:

Children's Names	Age	Adopted?	Deceased?	For any Yes answers, please provide explanation

(Please complete page 2)

MEDICAL INFORMATION

How would you describe your overall health?

Has there been any change in your weight in the past year? Yes No

If yes, please explain:

Has there been any change in your sleep patterns in the past year? Yes No

If yes, please explain:

Physician's Name:

Date and Report of last physical:

List any serious injuries or illnesses in the past ten years	List any current medications and for what purpose taken:

COUNSELING INFORMATION

Have you had counseling in the past? Yes ☐ No ☐

If yes, when? Name of counselor/therapist:

For what purpose?

Would you be willing to sign a ***Release of Information*** form giving permission to obtain records from your previous counselor? Yes ☐ No ☐

Describe briefly the major concern that brings you for counseling at this moment:

Describe what you have done about this concern prior to this appointment:

As you see yourself, what kind of person are you?

- I have read the **STATEMENT OF DISCLOSURE** and have had an opportunity to ask any questions.
- This is to certify that the above information is correct and hereby consent to counseling at **Agape Christian Counseling**, in full accordance with these terms described in the **STATEMENT OF DISCLOSURE.**

(If under 18, must be signed by parent or legal guardian)

Signature:____________________ Date:________

Signature:____________________ Date:________

Signature of Parent or Guardian if client is under 18 years of age

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Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Effective date: September 13, 2015

This notice describes Agape Christian Counseling's policies related to the use and disclosure of your protected health information. Protected health information is any information about health status, provision of health care, or payment for health care that may be linked to a specific individual. It includes any part of a client's medical record. This notice also describes your rights to access and control your health information.

Agape Christian Counseling has been and will always be totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and the ethics of the counseling profession.

Uses and Disclosures of Your Protected Health Information

We may use or disclose your health information without your prior authorization to provide treatment services, to authorize services from your insurance provider, to collect payment and to conduct healthcare operations. State and federal laws allow us to disclose your health information for these purposes.

A. Treatment
We may use or disclose your health information to provide, manage or coordinate your care or related services. In the event that your therapist is unavailable due to extended illness, an emergency, vacation or death, another licensed therapist on staff with Agape Christian Counseling may have access to your health information to provide care in their absence and to ensure your information is secure. Where your identity is included, a separate authorization may be required.

B. Payment
We will, at your request, prepare a bill identifying your diagnosis and procedure code to be given or sent to you and/or a third-party payer. Information may be shared with your insurance carrier to verify insurance coverage and/or benefits, to authorize treatment, to process your claims as well as information needed for billing and collection purposes. Agape Christian Counseling may bill the person in your family who pays for your insurance.

C. Healthcare Operations
Information may be used for certification, compliance and licensing activities.

D. Other uses or disclosures of your information, which do not require your consent
There are some instances where your therapist may be required to use and disclose information without your consent.

a) Your therapist is required by North Carolina State Law to report information if they believe you intend to do harm to yourself or another person, or when they believe a child or elder person has been or will be abused or neglected.
b) Your therapist may disclose information with law enforcement if a crime is committed on the premises or against your therapist.

Your therapist may disclose information as required by law such as a court order.

c) It may also be necessary to contact you regarding appointments, the need to reschedule or to discuss issues related to treatment or payment. In these instances, every attempt will be made to protect your privacy.

Agape Christian Counseling's Responsibilities

A. Provide Notice of Privacy Practices
We must provide you with our Notice of Privacy Practices on the first encounter we have with you and must abide by the terms of this Notice.

B. Minimum Necessary
We must limit the health information that is disclosed to the amount reasonably necessary when required to do so.

C. Electronic Communication Email and other electronic forms of communication are limited in terms of security of information. All reasonable precautions will be taken to protect your health information. Use of email to share, disclose, or discuss your health information should be limited. Your health information will not be faxed unless the identity of the person/provider receiving the information is known.

For all other circumstances, we may only use or disclose your health information after you have signed an authorization for release of information.

Your Rights

A. Right to confidential or alternative communication
Sometimes it is necessary to contact you about appointments or other matters. You have the right to request reasonable confidential communications or alternative means of communications of your protected health information.

B. Right to release your health records
No one, including family or outside healthcare providers, has access to your records without your written permission, except as listed above. You may consent in writing to release your records to others. You have the right to submit a written revocation of this authorization at any time, to the extent that action has not already been taken.

C. Right to inspect and copy your health and billing records
You have the right to inspect and obtain a copy of the information contained in your health records. Under limited circumstances, I may deny your request to inspect and copy. If you ask for a copy of any information, I may charge a reasonable fee for the costs of copying, mailing and supplies.

D. Right to add information or amend your record
You have the right to request an amendment of your record. A decision on your request will be made within 60 days. Under certain circumstances, your request to add or amend information may be denied. If your therapist denies your request, you have a right to file a statement that you disagree. Your statement and your therapist's response will be added to your record. To request an amendment, you must submit your request in writing and provide an explanation concerning the reason for your request.

E. Right to an accounting of disclosures
You have the right to submit a written request of an accounting of any disclosures, if any, we have made related to your health information. Information regarding disclosure is available for a specific time of no longer than six years. We will notify you of the cost involved in preparing this list.

F. Right to request restrictions on uses and disclosures of your health information
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing. In some circumstances, your therapist may not be able to adhere to such a request, if federal or state law requires an exception to the confidentiality agreement as in section D of Uses and Disclosures.

G. Right to complain
If you believe your privacy rights have been violated, please contact your therapist personally and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the North Carolina Board of Licensed Professional Counselors at 1 (919) 661-0820 and / or the U.S. Department of Health and Human Services at 1 (800) 367-6543. An individual will not be retaliated against for filing such a complaint.

H. Right to receive changes in policy
You have the right to receive any future policy changes secondary to changes in federal and state laws.

NOTICE OF PRIVACY PRACTICES: RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Client Name (Please Print): ____________________ **Date of Birth:** __________

2nd Client or Legal Representative Name (Please Print): ____________________ **Date of Birth:** __________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the ***"Notice of Privacy Practices."*** *I understand that if I have any questions regarding* the notice of my privacy rights*, I can contact* ***Agape Christian Counseling*** *at 704-849-0144.*

Client Signature or *Legal Representative for client

____________________ **Date:** __________

Relationship*: ____________________

2nd Client Signature____________________ **Date:** __________

Relationship*: ____________________

**** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, legal guardian, healthcare surrogate, etc.)***

__________ *Patient/Client refuses to acknowledge receipt of* **Notice of Privacy Practices**.

Signature of Staff Member: ____________________ **Date**: __________

Agapé Christian Counseling

COUNSELING FEES (per 50 minute session):

Effective January 1, 2016

Service	Therapist's Credentials			
	LPC, LMFT	*PhD*	*LPCA, LPCA & P-LCSW*	*Intern (Master's Level)*
Initial Visit	$130	$135	$100	$40
Individual Counseling	$115	$120	$95	$40
Marriage/Family Counseling	$115	$120	$95	$40

Other Fees:

Service	Fee
Telephone calls to therapist in excess of 10 minutes, preparation of letters for medical doctors, school officials, etc.	Billed at therapist's hourly rate (or any part thereof) for individual counseling as stated above
Court related activities (litigation, interviews, defense, communication with attorneys, testimony, travel, on-site time, etc.)	$115 per hour or any part thereof plus expenses. In case of overnight travel, maximum daily rate is $1,000, plus expenses. 48 hour notice must be provided for cancellation of court appearances or full fee will be charged.
Testing	Varies by test. Your therapist will discuss these with you prior to any assessment.
Copying, faxing or mailing of client records	$30 for the first 50 pages, $0.25 per page thereafter
Returned Checks for NSF	Amount charged by our bank, in addition to the cost of the session

Payment is expected at the time or in advance of the time the service is rendered. If you have an unpaid balance, no records, test results or evaluations will be released until the balance is paid in full. Nonpayment of fees will also result in the termination of any counseling services.

Payment:

Agape accepts the following method of payments:

- Cash or Money Orders. Please provide exact change because your therapist may not have change. If you overpay for the session, the overpayment can be credited toward your next session.

- Checks. Checks should be made payable to Agape Christian Counseling. Be sure your check has your physical address, phone number and driver's license # and state (e.g. NC). Postdated checks must be pre-approved.

- Debit or Credit Cards (Visa, MasterCard, Discover, Debit Cards, & Healthcare Payment Cards). We do not accept American Express at this time.

Agapé Christian Counseling

If you have any questions or concerns, please ask your counselor/therapist or the administrative personnel.

Method of Payment (Check one):

______**SELF PAY** (not using insurance or church/third party payment)

I agree to pay the full fee for my session. ***I understand and agree that I will be charged the full fee for a missed appointment or if I cancel an appointment with less than 24 hour notice.***

____

Client Signature (or Parent/Guardian if Minor) ***Date***

______**FILING FOR INSURANCE REIMBURSEMENT**

(Please present your insurance card and driver's license)

You will be expected to pay the full fee at each session. A completed HCFA form will be given to you to submit to your insurance company. **Blue Cross Blue Shield** claims will be filed electronically.

AGAPÉ CHRISTIAN COUNSELING has made every effort to obtain the correct information from your insurance company. ***The amount quoted is not a guarantee of coverage.*** The actual amount to be paid is not known until your claim has been reviewed and processed by your insurance company. Your insurance company may be given information about your diagnosis, cost, dates, and providers of any service or treatment you receive. ***I understand and agree that I will be charged the full fee for a missed appointment or if I cancel an appointment with less than 24 hour notice.***

____

Client Signature (or Parent/Guardian if Minor) ***Date***

______**CHURCH/THIRD PARTY PAYMENT**

With *prior approval and a signed* Partnership Agreement Form, Agapé Christian Counseling will bill a third party, e.g. church or other benefactor, for counseling services. The client will be responsible for all fees at the time of service if Agape has not received the signed form or if the number of agreed upon sessions has expired.

I agree to pay $________ per session. The church/third party listed below has agreed in writing to pay the remaining balance.

I understand and agree that I (not the church or the third-party) will be charged the full fee for a missed appointment or if I cancel an appointment with less than 24 hour notice.

____

Client Signature (or Parent/Guardian if Minor) ***Date***

Church Name/Third Party: ____

Contact:________________________________ **Phone:**__________________________