Lexington Christian Counseling

224 East Main Street
Lexington, SC 29072
(803) 808-5222
E-mail LCC@LexingtonChristianCounseling.org

FOR OFFICE USE ONLY

Ins? ☐ YES ☐ NO Ins. Co. Name: _____

Deduct?_____ Met? ☐ YES ☐ NO

Coverage Information: _____

_____

Therapist: ☐RT ☐AL ☐SR ☐DV ☐CL ☐NP ☐LK ☐INT

Date:_____

Therapist's Name: _____

I. Client Information

Primary Client Name _____

Birthdate_____ SSN _____

Hm. Phone # _____ Wk Phone # _____

Cell Phone # _____

Messages ☐Home ☐ Work ☐ Cell

Address _____

_____

Employer _____

Referral Sources: ☐ LBC ☐ Pastor ☐ Insurance/ EAP
☐Website ☐ Doctor ☐ School ☐ Another Client ☐ Phone Book
☐ Other, please specify: _____

Name of Referral Source _____

Primary Care Physician _____

Address of Physician _____

Do you attend church regularly? ☐ YES ☐ NO

If so, where? _____

Marital Status: ☐ Single☐ Married☐ Separated☐ Divorced☐ Widowed

Spouse's Name _____

II. Spouse Information (if spouse is a client)

Primary Client Name_____

Birthdate_____ SSN _____

Hm. Phone #_____ Wk Phone #_____

Cell Phone #_____ Pager # _____

May we leave a message at the home number? ☐ YES ☐ NO

Address_____

_____

Employer_____

Referral Source: ☐ LBC ☐ Pastor ☐ Insurance/ EAP
☐Website ☐ Doctor ☐ School ☐ Another Client ☐ Phone Book
☐ Other, please specify: _____

Name of Referral Source _____

Primary Care Physician _____

Address of Physician _____

Do you attend church regularly? ☐ YES ☐ NO

If so, where? _____

Marital Status: ☐ Single☐ Married☐ Separated☐ Divorced☐ Widowed

III. Child Information (omit if child is not a client)

Name of Child's School:_____ Grade _____

Is child seeing a guidance counselor? ☐ YES ☐ NO If yes, name of counselor: _____

Primary Parent or Guardian's Name: _____ Employer:_____

Home Phone #_____ Work Phone #_____ Emergency Number: _____

Parent or Guardian's Name: _____ Employer:_____

Home Phone #_____ Work Phone #_____ Emergency Number: _____

Stepparent's Name, if applicable: _____

IV. Other People Living with the Client(s)

Name: _____ Relationship: _____ Birthdate: _____

Name: _____ Relationship: _____ Birthdate: _____

Name: _____ Relationship: _____ Birthdate: _____

Name: _____ Relationship: _____ Birthdate: _____

V. Children not Living in the Home

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Client Name_____

What are your reasons for coming to therapy? _____

_____

_____

Briefly describe how and when your problems began: _____

_____

_____

Have you ever been in counseling before? ☐ YES ☐ NO If yes, please complete the following information on each counselor you saw:

1. DATES - FROM:_____ TO_____ Counselor's Name _____
   Circumstances? _____
   _____
2. DATES - FROM:_____ TO_____ Counselor's Name _____
   Circumstances? _____
   _____
3. DATES - FROM:_____ TO_____ Counselor's Name _____
   Circumstances? _____
   _____

Did you complete the course of treatment? ☐ YES ☐ NO

Are you presently involved in any legal proceeding? ☐ YES ☐NO If yes, please explain: _____

_____

Identify any habits, practices, or behaviors that you would like to change: _____

_____

How many drinks of alcohol do you consume weekly? _____

How many cigarettes do you smoke weekly? _____

List three (3) goals you have for personal improvement:

1. _____
2. _____
3. _____

List four (4) major strengths or abilities you have:

1. _____
2. _____
3. _____
4. _____

Does your personal history include any of the following? Mark any that apply with an "X":

☐ alcohol abuse	☐ child of an alcoholic	☐ adoption	☐ eating disorder	☐rape
☐ other drug abuse	☐ gambling addiction	☐ divorce	☐ sleep disturbance	☐ incest
☐ sexual abuse	☐ domestic problems	☐ divorce of parents	☐ marital separation	☐ Special Education
☐ physical abuse	☐ death of a close person	☐ residential treatment	☐ depression	☐school problems
☐ sexual addictions	☐ incarceration or parole	☐ suicide attempt	☐ trauma	☐ self-mutilation

☐ mental illness – type: _____

Are you presently taken any medication? ☐ YES ☐ NO If yes, please list name of medication(s) and dosage(s): _____

_____

Name of Doctor(s) prescribing medications_____

Is there any information that has not been covered that your counselor should know (please use back if needed): _____

_____

Payment Information

Who will be responsible for payment for counseling services rendered? Please include address and phone if not on first page. _____

_____

If client is a child, the parent bringing the child will be responsible for counseling fees. We will not bill for services rendered.

I certify that I will accept full responsibility for payment for sessions and/or services rendered by Lexington Christian Counseling (LCC) and its counselors.
Signed:_____ Date:_____

Fees for additional requested services, such as testing, will be paid for prior to the appropriate session.

LCC WILL BE GLAD TO FILE INSURANCE CLAIMS FOR YOU. HOWEVER, FEES FOR SERVICE ARE THE ULTIMATE RESPONSIBILITY OF THE CLIENT IF THE INSURANCE COMPANY DOES NOT PAY AS EXPECTED. CLIENTS ARE RESPONSIBLE FOR VERIFYING THEIR INSURANCE COVERAGE USING THE ATTACHED GUIDELINE SHEET.

Primary Insurance Information (if applicable)

Insurance Company: _____
Address: _____
_____
Phone: _____
Name of Insured Person: _____
Relation to Client:_____
Address of Insured: _____
_____
Birthdate:_____ SSN: _____
Policy No: _____ Group No:_____

Secondary Insurance information (if applicable):

Insurance Company: _____
Address: _____
_____
Phone: _____
Name of Insured Person: _____
Relation to Client:_____
Address of Insured: _____
_____
Birthdate:_____ SSN: _____
Policy No: _____ Group No: _____

IF YOU WISH LCC TO FILE FOR INSURANCE REIMBURSEMENT, ALL OF THE ABOVE INFORMATION MUST BE COMPLETED, AS WELL AS A COPY MADE OF YOUR INSURANCE CARD, SO WE CAN SUPPLY A STATEMENT ACCEPTABLE BY MOST COMPANIES. THE FOLLOWING RELEASES ARE ALSO REQUIRED TO PREPARE AND FILE INSURANCE STATEMENTS. IF YOU WISH TO FILE YOUR OWN CLAIMS, PLEASE INDICATE BELOW AND WE WILL SUPPLY YOU WITH THE NECESSARY INFORMATION.

NOTE: CLIENTS WHO WISH US TO FILE THEIR CLAIMS ARE ASKED TO PAY FOR SESSIONS IN FULL UNTIL WE RECEIVE WRITTEN CONFIRMATION FROM THEIR INSURANCE COMPANY AS TO COVERAGE AMOUNTS. ALL CLIENTS ARE ASKED TO PAY THEIR PORTION FOR THE THERAPY FEE AT THE BEGINNING OF EACH SESSION.

☐ Yes, please file my claims for me ☐ No, I plan to file my own claims
(Note: Some insurance plans, such as Tri-Care, require us as providers to file the claims.)

I certify that I will accept full responsibility for payment for sessions and/or services rendered in the event that my insurance company does not reimburse LCC fully.
Signed:_____ Date:_____

I authorize payment of medical benefits to Lexington Christian Counseling for services rendered.

Signed:_____ Date:_____
(Signature of Insured or authorized person)

I authorize the release of any medical information necessary to process this claim.

Signed:_____ Date:_____
(Signature of Insured or authorized person)

I authorize my counselor to obtain from/release information relevant to my care to my Primary Care Physician

Signed:_____ Date:_____
(Signature of Insured or authorized person)

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Notice of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information **cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.** The exception to this are defined immediately below. Additional information regarding your rights as a client can be found in Consent for Treatment.

Use or disclosure of the following protected health information
does not require your consent or authorization:

1. Uses and disclosures required by law.
2. Uses and disclosures about victims of child and elder abuse and neglect.
3. Uses and disclosures for health and oversight activities – *like correcting records or correcting records already disclosed*.
4. Uses and disclosures for judicial or administrative proceedings – *like a case where you are claiming malpractice or a breach of ethics.*
5. Uses and disclosures for law enforcement purposes – *like if you intend to harm yourself or others.*
6. Uses and disclosures for research purposes – *like using client information in research; always maintaining client confidentiality.*
7. Uses and disclosures to avert a serious threat to health or safety.
8. Uses and disclosures for Workers' Compensation claims – *like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim.*

Your Rights as a Counseling/Therapy Client under HIPAA

- As a client, you have the right to see your counseling/therapy file. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.*
- As a client, you have the right to receive a copy of your counseling/therapy file. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.* You will be required to pay any copying fees at $.50 per page.
- As a client, you have the right to request amendments to your counseling/therapy file.
- As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees at $.50 per page.
- As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to counseling or therapy, you will receive an exact duplicate of these pages and your Consent to Treatment—both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read, and understand both documents. This certificate will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights Statement and the Consent for Treatment. Your counselor or therapist will be happy to explain these documents further.

For internal complaints regarding your counselor/therapists compliance with the HIPAA regulations, please contact Lexington Christian Counseling's HIPAA administrator, Gail Barnett, Office Manager. She can be reached at 803-808-5222.

LCC Counseling Agreement & Consent for Treatment

PLEASE COMPLETE AND SIGN THIS PAGE AND GIVE IT TO YOUR COUNSELOR WITH YOUR INTAKE PAPERWORK.
THE FOLLOWING PAGE IS A CLIENT COPY OF THIS PAGE FOR YOUR RECORDS.

Confidentiality

Information disclosed in this intake packet and within counseling sessions will be kept in strictest confidence unless the following situations occur: 1) an individual's intent to harm himself, 2) an individual's intent to harm others, and 3) any matter that by law must be reported.

Relationships

In accordance to the ethics code of therapists' licensing bodies, a therapist will never have a sexual relationship with a client. Any breech of this policy should be reported to the therapist's licensing body and the Director of LCC immediately. Addresses of licensing bodies are posted in the LCC reception area.

Payment

Clients must make payment prior to each session in the plastic sleeve at the office desk. As a small non-profit counseling center, we must minimize the costs of billing. LCC may find it necessary to mail information to your home on occasion. Therapists are instructed to refrain from scheduling the next session if payment is not deposited as outlined. **Until a client's insurance coverage can be verified, he or she will be responsible for the full amount. We are only able to accept cash or personal checks. There will be a $25 charge for returned checks**.

All appointments that are cancelled without 24 hours notice will automatically be charged **to the client** for the full amount, as insurance companies do not feel accountable for missed appointments. Full payment will also be charged to church members who do not give 24 hours notice.

Appointments

Appointments are made at times reserved exclusively for you. If you must cancel, you are requested to do so no less than 24 hours in advance. Cancellation calls made after hours are acceptable and preferred by leaving a voicemail message in the appropriate counselor's voicemail box. Except for emergencies, you will be billed for appointments missed without sufficient notice. Appointment times are scheduled in 60 minute blocks and we do our best to stay on schedule. Initial appointments will be scheduled for 80 minutes for the same fee. All clients are asked to pay the therapy fee before each session.

Contact

In an effort to provide quality-counseling services, LCC has a voicemail system in place to take calls in the event we are unable to answer your call. In addition, our confidential voicemail system can be accessed 24 hours a day. Cancellation calls made after normal business hours are acceptable and preferred by leaving a voicemail message in the appropriate counselor's voicemail box. Messages left in voicemail will be addressed as soon as possible and emergency and present client's calls take priority. Emergency phone calls should be placed through the center's emergency number which is accessed by calling (803) 808-5222, extension 0.

Informed Consent

The client has the right to receive services regardless of race, creed, color, physical or mental handicap. Since counseling is a cooperative process, it is in the best interest of the client to play an active role in therapy and regularly review treatment goals and progress with his or her counselor. The client has the right to refuse services or terminate therapy at any time. Since LCC is a nonprofit entity, the client may contribute to help others to receive counseling at any time and understands that the contribution will be anonymous. See www.LexingtonChristianCounseling.org for more details. As in all medical and psychological treatment, no guarantees can be made regarding treatment outcomes.

Supervision/Consultation

In order to provide quality services, counselors at LCC have a system of peer supervision and consultation about clinical and legal issues that arise in ongoing therapy. Our purpose is to use available expertise to best counsel our clients. Of course these consults are held in strictest confidence and every effort is made to restrict the identity of each individual. Signing this consent is voluntary; however, your counselor reserves the right to refer you to another therapist outside of our center if at any point your counselor thinks that quality care is not being provided. Because we are an active training site, a graduate student may be available for co-therapy at no charge.

Prayer

We are a Biblically-based counseling center and believe that the Holy Spirit is available at our petition to be our Counselor. We may ask if you would allow us to pray with you and we will be praying regularly for each of our clients. Please feel free to discuss your feelings with us about your desire for prayer in your sessions. *And I will ask the Father, and He will give you another Counselor to be with you forever… the Spirit of Truth. – John 14:16-17*

But when He, the Spirit of Truth, comes, He will guide you into all truth. – John 16:13

I acknowledge that I have received and read Lexington Christian Counseling's Consent for Treatment Statement and HIPAA Client's Rights (version 03/03). I further acknowledge that I seek and consent to treatment with the staff of Lexington Christian Counseling. My signature below confirms that I understand and accept all the information contained in the aforementioned statements. I have also read and received a copy of the "Fees for Additional Requests" for service.

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(if relative, please state relationship to client)

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Signed_____Date_____
(if relative, please state relationship to client)

Signed_____Date_____
(if relative, please state relationship to client)

Lexington
Christian Counseling

224 East Main Street
Lexington, SC 29072
803-808-5222 - fax 803-957-2062

Fees for Additional Requests

Copies - $1.00 per page for copying any records.

Written Documents – One half of the standard session rate ($45.00) per hour for any written documents requested by clients, such as affidavits, summaries/letters to teachers or legal professionals. The exception is a written excuse for work or school for attendance purposes.

Consultation – Special phone call consultations and staffing such as collaborating with lawyers, DSS workers, or Guardian Ad Litems, require significant time and attention. Time spent will be prorated at one-half of the standard session rate ($45) per hour.

Meetings – Attendance at any meetings held away from LCC site will be assessed at the client's regular session charge per hour including travel time. The mileage fee of 44.5 cents per mile will also be added.

Court Appearances – While our counselors do not accept clients who desire testimony in court, we will comply when subpoenaed. The entire day will be designated at $90 per hour (8 hours), totaling $720/day plus travel expenses at 44.5 cents per mile.

Please give your counselor at least one week's notice if you require such services and pay in full in advance since insurance companies often do not cover such request.

INSURANCE CONTACT FORM

(Required)

Lexington Christian Counseling will be glad to file your insurance for you. However, fees for sessions are the ultimate responsibility of the client if the insurance company does not pay as expected.

Clients are responsible for verifying their insurance coverage. The following information is to assist you in being aware of what information needs to be collected before filing a claim.

1. **The intake form must be filled out completely. All insurance information must be included as well as a copy of both sides of your insurance card.**

2. **The insurance-related releases on page 3 of the intake packet must be signed and dated.**

3. **To verify your coverage, call the 800 number of your insurance company to request specific coverage information. (If there are several phone numbers listed on the back of your card, call the one associated with benefits or mental health.)**

Ask the following:

- Do I have mental health coverage?_____
- Does it require me to meet a deductible?_____ If so, amount of deductible _____.
- Have I met it?_____
- Does it cover services rendered by a Licensed Marriage and Family Therapist (LMFT)—Robin Temples? ☐

  OR a Licensed Independent Social Worker (LISW-CP)— Sarah Rogers? ☐ ***OR*** a Licensed Professional Counselor (LPC)— Angie Lamp? ☐ (LPC)— David Van Horn? ☐
- Must the therapist I see be on a preferred provider list?_____
- Is my therapist (Robin, Sarah, Angie, David) on that list?_____
- What is my required co-payment or co-insurance?_____
- Must sessions be pre-certified?_____ If insurance representative inquires reason for counseling, give general category of stress. If the therapist must start the pre-certification, what number must be called to do this?_____
- **If sessions are approved, what is the authorization number?** _____ Number of sessions Approved: _____ Start Date: _____ End Date: _____
- **To what address should my claim be sent?**

  _____

  _____

4. **If you have questions or need assistance, please call the office (808-5222) and leave a message for the Office Manager (extension 9).**

Please return a copy of this form with your paperwork. Also we need a copy of the front and back of your insurance card.

Email to: LCC@LexingtonChristianCounseling.org