



LATE CANCELLATION POLICY

CCS understands that there are times when appointments need to be changed due to unforeseen circumstances. When these occur, clients agree to call CCS within 24 hours of their scheduled appointment to cancel or reschedule. The first “Late Cancel” or “No Show” will not incur a charge, but all subsequent missed appointments and late cancellations will incur a charge equal to half the cost of the scheduled appointment.

INSURANCE POLICY

- As a courtesy to their clients, CCS bills primary insurance companies, including employee assistance programs (EAPs).
- Balances not paid by insurance within 45 days from the day a claim is submitted, for any reason, are the responsibility of the client.
- Co-pays, co-insurance, and deductibles are due at the time of service.
- Prior-authorization for services is the responsibility of the client to obtain. Charges denied by the client’s insurance company due to lack of pre-authorization will be the responsibility of the client.
- Clients agree to notify CCS of changes to their insurance and will be held responsible for outdated insurance errors.
- CCS has the right to bill the client directly for charges when there are incomplete lines or boxes within the Insurance Benefits Section of this application and indicates the client is unaware of their insurance coverage. CCS has the option, but not the directive, to call the client’s insurance company to obtain coverage information and fill out the form.
- The Client understands that CCS encourages them to contact their insurance company to be informed of their coverage.
- CCS does not bill secondary insurance companies. The Client is responsible for charges not covered by their primary insurance company. After making their payment to CSS, the client may seek reimbursement from their Secondary Insurance Company by sending them a copy of their CCS receipt along with their primary’s explanation of payment.

CONSENT TO TREATMENT AND PAYMENT AGREEMENT:

As a client or legal guardian, I have been given the opportunity to discuss any questions or concerns regarding Centerpoint Counseling Services, LLC’s clinical treatment and care and I consent to treatment. I have read, understand, and agree to their Insurance Policy, Payment Policy, and Late Cancellation Policy. The information I have provided on this form is complete and accurate to my knowledge.

Printed Name: _____ Signature: _____ Date: ____/____/____

Printed Name: _____ Signature: _____ Date: ____/____/____



PERSONAL MEDICAL HISTORY

Primary Care Physician: _____ Location: _____; Tel #: (____) _____

Date of Last Physical: ____/____/____ Date of last tetanus shot: ____/____/____

Dentist: _____ Location: _____; Tel #: (____) _____

Eye Doctor: _____ Location: _____; Tel #: (____) _____

Psychiatrist: _____ Location: _____; Tel #: (____) _____

Other: _____ Location: _____; Tel #: (____) _____

Please describe your current medical condition: _____

Please list any prescription and non-prescription medications you are taking:

#1 _____ #2 _____ #3 _____

#4 _____ #5 _____ #6 _____

Do you have any drug sensitivity or allergies? (describe) _____

Have you ever been told you had on any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Lung disorder | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Disease or disorder of the digestive tract | <input type="checkbox"/> Any form of cancer |
| <input type="checkbox"/> Disease of the kidney | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Disease or disorder of the blood? (describe) |
| <input type="checkbox"/> Any physical defect or deformity? (describe) | <input type="checkbox"/> Any vision or hearing disorders? (describe) |
| <input type="checkbox"/> Any contagious disorders? (describe) | <input type="checkbox"/> Any life-threatening conditions? (describe) |

Have you ever been treated by a physician or been disabled or hospitalized during the last year? (Describe) _____

Have you had or been advised to have a surgical operation within the last five years? (Describe) _____

Family history -- List important medical problems of your parents:

Mother: _____ Father: _____



RELEASE OF INFORMATION

I consent to allow Centerpoint Counseling Services, LLC to exchange my personal and clinical information, verbal or written, with the listed individual(s) or entities.

1.

Name:	Organization (if any):
Relationship to Client:	
Street Address:	City, State, and Zip:
Home Ph #:	Cell Ph #:
Work Ph #:	Email address:

2.

Name:	Organization (if any):
Relationship to Client:	
Street Address:	City, State, and Zip:
Home Ph #:	Cell Ph #:
Work Ph #:	Email address:

3.

Name:	Organization (if any):
Relationship to Client:	
Street Address:	City, State, and Zip:
Home Ph #:	Cell Ph #:
Work Ph #:	Email address:

4.

Name:	Organization (if any):
Relationship to Client:	
Street Address:	City, State, and Zip:
Home Ph #:	Cell Ph #:
Work Ph #:	Email address:

Printed Name of Patient

Signature

Date ____/____/____



THIRD-PARTY BILLING AGENT POLICY AND AGREEMENT

Name of Client: _____ DOB: _____

CCS maintains a Third-party Billing Agent Policy which allows a person or entity other than the client to accept financial responsibility for the client's charges and they adhere to CCS's Payment Agreement. Examples include employers, state or county jurisdictions, extended family members, or ecclesiastical leaders. The regular and customary hourly rate is \$80.00 for each psychotherapy/counseling session, with the exception of the \$105.00 initial diagnostic assessment. Each standard consultation is a 50-minute hour for individuals, couples, and families and is considered a one hour session for billing purposes. When the client has listed an insurance company in their file to submit claims to, CCS seeks payment from their insurance company prior to billing the Third-party Billing Agent.

Third-party Billing Agents may pay with cash, credit cards, Paypal, and checks (personal, cashier, business) at our office location or by mail at 393 E. 2nd N., Rexburg, ID 83440, over the phone at (208) 359-4840, and online at <http://www.centerpcs.com>.

Third-party Billing Agents are eligible to obtain clients' confidential clinical treatment and progress information when their clients have signed a legal "Consent for Release of Information" listing the Third-party Billing Agent.

I (please print full name), _____, understand Centerpoint Counseling Services Third-party Billing Agent Policy and have had any concerns or questions regarding it satisfied. I further agree to be the above listed client's Third-party Billing Agent.

Signature: _____ Date: _____

<input type="checkbox"/> Individual		<input type="checkbox"/> Organization
Last Name	First Name	Bill To:
Soc. Sec. #:	Date of Birth:	

Relationship to Client:		
Address:	City:	State & Zip:
Mailing Address:	City:	State & Zip:
Permanent Address (if different than above):	City:	State & Zip:
Home Ph #:	Cell #:	
Work Ph #:	Email:	

Please check the following that apply: Please send me statement charges by mail
 Please pay with the following credit card:

<input type="checkbox"/> Visa®	<input type="checkbox"/> MasterCard®	<input type="checkbox"/> Discover®	<input type="checkbox"/> American Express®
Credit Card Number: _____		Exp. Date: ____/____	CVC Code: _____