

NEW CLIENT INFORMATION

Welcome to LifePointe Counseling, LLC and thank you for choosing us for your counseling and/or medical needs! We are committed to providing you the best possible care. We hope your relationship with us will bring you hope and healing with whatever concern you are currently dealing with. Please carefully read the following information before signing at the appropriate sections:

All providers at LifePointe Counseling, LLC are independent contractors. While the providers share a name and office space, we want you to know that the provider you see is fully responsible for his/her services. Their professional records are the property of LifePointe Counseling, LLC. However, no other member of our group can have access to them without your specific written permission. In addition, your provider is solely responsible for matters concerning your clinical care and all questions about that care should be addressed to them. However, if you feel your concerns are not being heard or addressed, you should contact Kate Bingham, Practice Manager via email at admin@lifepointecounseling.com or via phone at 314-849-2120 option #3.

Appointments: Your time is valuable – and so is your providers'. If you need to cancel an appointment, we require a minimum of 24 hours notice to allow us to accommodate schedule changes. If you are not able to call and cancel during normal business hours (**9-5, Mon-Thu**) please call our scheduling line at 314-849-2120 option #1 to leave a confidential message on our automated voice mail system. Otherwise, you will automatically be charged a **late cancellation/no show fee at a minimum of \$75 per missed session**. Should a client no-show (meaning not attend a scheduled appointment **and** fail to cancel/notify the office beforehand) and/or cancel for three consecutive appointments, all future appointments scheduled will be removed. After the client re-establishes communication by making and attending one appointment, future appointments can be rescheduled.

Emergencies: In case of an after-hours emergency, please go to the nearest emergency room, dial '911' or dial '988' for help. Or you can call the Behavioral Response Hotline at **1-800-811-4760 in the event of an emergency**. LifePointe Counseling, LLC does not provide emergency services. We do not have 24-hour staff. Arrangements for after hours or nontraditional services must be discussed and established in writing with your provider.

Financial Responsibility: You are fully responsible for payment of all services provided to you at the time of your visit. This includes, but is not limited to insurance **deductibles, co-pays and co-insurance payments**.

Please make all checks payable to "**LifePointe Counseling, LLC**". You also may pay via cash, credit, debit or HSA card (please note an additional 2% surcharge fee is applied to all **credit card payments**). **We require that a credit, debit, or HSA card to be on file, even if you intend to pay by cash or check. An initial payment of \$30.00 is required at your first visit.** Should your appointments be covered completely by your insurance, we will refund this back to you as soon as your first claim is processed. Payments made by cash must be made in **exact change**, as no cash money is kept on site. Please note that accounts which become delinquent by sixty (60) days or more will be subject to a fee surcharge as allowed under Missouri law. Past due accounts are subject to 5% interest on the balance after sixty (60) days. For details on our financial policies, please see the admin staff or visit our website at www.lifepointecounseling.com and click on the "FORMS" tab, which will direct you to a webpage where you can download our document entitled "Financial Policies".

If any payments are made by check and returned as "insufficient", your account will be billed a \$40 charge for banking fees. The fee may exceed \$40 if insurance is involved and a claim must be resubmitted. Keep in mind that we are only able to discuss your account with you, your guarantor, your insurance company, or someone else you have designated in writing, due to medical privacy laws. **Should any of your accounts at LifePointe Counseling, LLC become delinquent beyond 60 days, you may no longer be able to schedule an appointment or receive prescription refills.**

Legal Expenses and Court Appearances: Occasionally, LifePointe Counseling, LLC providers may be required to participate in legal proceedings related to a client's care (for example, being subpoenaed to testify or provide records). Please note that providers are not typically willing to participate in legal proceedings unless legally compelled. **Should your provider be subpoenaed or otherwise required to appear in court, prepare documents, or consult with attorneys regarding your case, you (or the requesting party) are responsible for all related professional fees.**

Healing Hearts ♦ Restoring Hope

Professional fees for legal preparation and appearance are billed at a minimum of **\$250.00 per hour**, with a **minimum of four (4) hours for any court appearance, regardless of if testimony is ultimately provided**. This fee covers travel, wait time, testimony, and all associated preparation or correspondence. Additional time required for preparation of records, reports, or communication with legal representatives will be billed at the same hourly rate. Payment for legal services is due in advance of any scheduled appearance or document preparation unless otherwise arranged in writing.

These policies exist to protect your provider's clinical neutrality and ensure that valuable therapy time is not diverted to legal matters. If you anticipate any potential for your provider's involvement in legal proceedings, please discuss this with them as early as possible.

Insurance Billing: No providers at LifePointe Counseling, LLC bill to Medicare/Medicaid. LifePointe Counseling, LLC submits claims to **in-network health insurance companies only**. If you choose to see a provider that is not in your network, you are required to make full payment at the time of service. We can provide you with a copy of your paid bill to submit to your insurance for out-of-network reimbursement.

If you and your provider determine that you are eligible for a reduced rate private pay fee schedule, the encounters recorded at that rate are not eligible for insurance reimbursement.

It is your responsibility to know your insurance's coverages/benefits. We strongly recommend that you verify all your insurance benefits prior to your first visit. Specifically, we recommend that you know your co-pays/co-insurance, deductibles, authorization requirements, etc., prior to your first visit.

If your insurance coverage/plan changes, you must contact us with this information prior to your next visit, if possible. That way, both you and your provider can be sure that the visit will be covered and what benefits/payments apply. You are responsible for the co-payment(s), deductible, and non-covered expenses as determined by your insurance plan. Please know that an insurance company's quotation of benefits is **not a guarantee of payment** and **you are responsible for any fees/services refused by your insurance plan**.

Confidentiality: Your patient records are the property of LifePointe Counseling, LLC and are treated as confidential. Your records will not be released without your executed written consent unless special circumstances arise. For example, we are obligated to release certain information to get claims processed by your insurance company. Please talk to our administrative staff if you have any further questions.

LifePointe Counseling, LLC providers do not have encrypted email. Text messages are **NOT** secure and therefore should not be used to transfer private or sensitive information. If you choose to communicate with your provider via electronic means, you do so with the understanding that your privacy may not be guaranteed electronically. Also, a copy of email or written communication sent to providers working with LifePointe Counseling, LLC will be maintained in the clinical record of the person served and may not be released to other providers. Please ask your provider for the secure fax number, voicemail number, and mailing address to send information. Best practice for electronic communication is to schedule or reschedule appointments only.

Contact Information: It is vital that you keep your contact information up to date with our admin staff. If any of your information changes, please let us know so we can update your records. This would include any changes to your surname, address, home/cell/work phone numbers, marital status, employer/school, emergency contact information, primary care physician, and/or financial responsible party (Guarantor of your account balances). Without up-to-date information we may be unable to contact you to confirm, reschedule or cancel an appointment, file your insurance claims properly, and/or refill your prescriptions.

Services Rendered: I understand that seeing a provider today is not a guarantee that future therapy services and/or medication management services will be provided. I understand that the first few sessions with my therapy provider are a time for both the provider and client to discuss and assess the issues that the client wants to address. During this time both parties will also determine whether the therapeutic relationship is a good fit for both parties. Because there are many different types of providers who specialize in a variety of areas, I understand that I may be referred to another provider for more specialized care.

I have read and understand all the above information, agree to the terms/conditions set herein, and consent to receive treatment at LifePointe Counseling, LLC.

Client/Guardian Signature

Date

CLIENT REGISTRATION

1. Patient Name _____
(Last) _____ (First) _____ (Middle Initial) _____ (Nickname) _____

2. Address (Street, City, Zip) _____

3. Primary Phone: () _____ Cell Home Work 4. Secondary Phone: () _____ Cell Home Work

5. Gender: M F Other _____ 6. Marital Status: S M D W 7. Birthdate _____ Age: _____

8. Email Address: _____ 9. Soc. Sec. #: _____

10. Employer: _____ Occupation: _____ 11. Student/School: _____ Full-Time Part-Time

12. If dependent child, are custodial parents: Married Separated Divorced Other _____

13. Primary Care Physician: _____
(Name) _____ (Phone) _____

14. IN CASE OF EMERGENCY NOTIFY: Name _____ Relationship _____ Phone () _____
Full Address _____

~ Financially Responsible Party (Guarantor) Information ~

If same as patient, please complete only question #1 in this section.

1. Guarantor Name _____
(Last) _____ (First) _____ (Middle Initial) _____ (Nickname) _____

2. Guarantor Address (Full) _____

3. Guarantor Relationship to Patient (check one): Spouse Mother Father Sibling Friend Other _____

4. Primary Phone: () _____ Cell Home Work 5. Secondary Phone: () _____ Cell Home Work

6. Special Financial Arrangements: _____

~ Insurance Information ~

1. Do you have insurance? YES NO (If yes, please complete below) **** LifePointe does not provide Out-Of-Network billing ****

2. *Primary Insurance Co. Name: _____ Claims Phone #: _____
Insurance Claims Address: _____

3. Subscriber's Name: _____ 4. Relation to Client: Self Spouse Parent Other _____

Employer: _____ Subscriber SSN: _____

5. Member ID # _____ 6. Group ID # _____ 7. Subscriber Birthdate: _____

8. *Secondary Insurance Co. Name: _____ Claims Phone #: _____
Insurance Claims Address: _____

9. Subscriber's Name: _____ 10. Relation to Client: Self Spouse Parent Other _____

Employer: _____ Work Phone: () _____

11. Member ID # _____ 12. Group ID # _____ 13. Subscriber Birthdate: _____

IF YOUR LIFEPOINTE COUNSELING, LLC PROVIDER IS CONTRACTED TO BILL YOUR INSURANCE PLAN, PLEASE SIGN THE FOLLOWING SECTION: ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to LifePointe Counseling, LLC the amount due for services rendered to me or my dependents. RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to my dependent or me. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNED: _____ DATE: _____
Insured _____ Patient/Guardian _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by LifePointe Counseling, LLC. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan.

Guarantor Signature (Patient signature, if patient is guarantor) _____ DATE: _____

WHO REFERRED YOU? / HOW DID YOU HEAR ABOUT US?

Physician LifePointe Staff Member Friend Church: _____
 Facebook Psychology Today JoyFM/Radio Other: _____

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS

Please note that a copy of our Payment Policies, HIPAA Statement, Notice of Privacy Policies and Client Rights Statement, and other important documents are available on our website at www.lifepointecounseling.com. You may access these documents by going to our website, selecting the "FORMS" tab, and then clicking on the corresponding document.

Areas within (_____) are to be initialed by the client or authorized person.

FINANCIAL POLICIES: I acknowledge having been offered LifePointe Counseling, LLC's Financial Policies document. (_____)

PRIVACY POLICY: I acknowledge having been offered LifePointe Counseling, LLC's Notice of Privacy Policies and Client Rights Statement. (_____)

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by LifePointe Counseling, LLC and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of LifePointe Counseling, LLC. I authorize LifePointe Counseling, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that LifePointe Counseling, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

Client or Authorized Person Signature

Relationship

Date

Witness Signature

Date

~ Child and Adolescent Consent for Treatment (If Applicable) ~

Patient Name (printed): _____ Birthdate: _____
Last Name *First Name* *Middle Initial*

I certify that I am the (check one) father mother legal guardian of the above-named child/adolescent and that I do have legal custody of the above-named child/adolescent. I, hereby, give my authorization and consent for the above-named child/adolescent to receive outpatient assessment/therapy from (therapist name) _____.

Printed Name: _____

Signature

Date

~ Divorce/Legal Separation Collection Policy (If Applicable) ~

It is the policy of LifePointe Counseling, LLC that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child's/adolescent's treatment regardless of any financial arrangement for payment of the child's/adolescent's medical care, either oral or written, with the child's/adolescent's other parent or responsible party. LifePointe Counseling, LLC. assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care. **I have read, understood and agree to the above policy:**

Printed Name: _____

Signature

Date

Witness

Date

CLIENT QUESTIONNAIRE

Please complete as much of this information as possible and give this form to your health care provider at your first visit. Please note that if the provider you are seeing is on your insurance panel, we must have a copy of your current insurance information prior to your first visit. Some insurance companies will not cover your visit if it has not been pre-certified. Please make every effort to know and understand your mental health insurance benefits prior to your visit(s) to LifePointe Counseling, LLC.

Name: _____ **Date:** _____

Please give us a brief description of your need for counseling or psychiatric care:

Please answer the following questions by circling either Yes or No. If Yes, please provide a brief description of the problem area:

Anxiety/Stress – Yes or No

Uncomfortable in Social Settings – Yes or No

Compulsions/Addictions – Yes or No

Appetite Changes – Yes or No

Sleep Changes – Yes or No

Concentration/Focus Problems – Yes or No

Work/School Impairment – Yes or No

Difficulty Caring for Self/Family/Home/Children – Yes or No

CLIENT QUESTIONNAIRE (continued)

Family Conflicts – Yes or No

Spiritual Problems – Yes or No

Depression – Yes or No

Feelings of Hopelessness/Despair – Yes or No

Self-Harm – Yes or No

Suicidal Thoughts – Yes or No

Suicidal Plans – Yes or No

Suicidal Attempts – Yes or No

Previous Hospitalization – Yes or No

Previous Counseling – Yes or No

Current Counseling – Yes or No

Medication History (List **current** medications here, and provide your complete history on separate page)

THOROUGH MEDICATION HISTORY

Medication Name (Please Include Dosage/Mg)	Date(s) Prescribed/Taken	Side Effects

CREDIT CARD AUTHORIZATION FORM

Your credit card will be entered at first visit. For security purposes, the system automatically encrypts this information so that no one can access or alter the full card number following the initial entry. By completing and signing this form, I authorize LifePointe Counseling, LLC to keep my signature on file and to charge my credit/debit/HSA card for copays, fees and account balances as indicated below:

CLIENT NAME: _____

CARDHOLDER NAME: _____

(Exactly as it appears on card)

Mailing Address: _____

City, State, Zip: _____

CARD TYPE (circle one): Credit Debit HSA

CARD COMPANY (circle one): Discover Mastercard Visa American Express

E-Mail Address (for digital receipts): _____

Cardholder Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

PLEASE NOTE: CREDIT CARDS ONLY are subject to 2% surcharge fees.

LifePointe Counseling LLC utilizes the integrated payment system, Paya, to process all payments via a virtual terminal. Paya is backed by 128 bit Secure Socket Layer (SSL) technology for reliable transaction encryption and fraud prevention. Paya is HIPAA and PCA compliant.