CHRISTIAN COUNSELING ASSOCIATES, INC.

Patient Information

Full Name: _____ Gender _____ Birth Date _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address:_____City_____State_____ Zip Code_____

Spouse/Children/Others in the home:	Relationship:	Others in home	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Under any Civil Protection Order?_____
Date of Marriage:_____Previous Divorce?_____Highest Education Level completed_____
Employer (or School): _____ Occupation:_____
How did you hear about Christian Counseling Associates, Inc.?_____

MEDICAL INFORMATION:

Primary Physician: _____ Address: _____
Phone: _____ Date of Last Exam: _____ Outcome of Exam: _____
Illnesses/Conditions (please include any psychiatric diagnoses): _____
Medications currently taking (please include dosages):_____
Known Allergies: _____

HEALTH INSURANCE INFORMATION:

PRIMARY Insurance Company Name: _____
Policy Holder's Name: _____ Date of Birth: _____ Gender _____
Employer: _____Policy Number: _____ Group number: _____
Client's Relation to Policy Holder: _____ Terms of Mental Health Benefits _____
SECONDARY insurance Company if any: _____

Who is responsible for payment of fees? _____
Address if different from above: _____

Cancellation / Missed Appointment Policy

If you are unable to keep your appointment, kindly **provide notice by 5pm the day before** to avoid being assessed a **$60 missed appointment fee. Repeat missed appointments could lead to discharge from the practice.** Appointments can be canceled by calling our office at **410-995-5587**. Messages can be left 24-hours a day. Please sign below indicating that you are aware of this policy.

_____ _____
Signature of Patient or Guardian Date

Financial Policies Concerning Insurance and Assignment of Benefits

I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Christian Counseling Associates, Inc. for services rendered. I certify the information I have reported regarding my insurance is correct. If the information is found to be incorrect, I understand I will be responsible for providing correct information or will be responsible for the charges. I authorize the release of any information, including medical information, needed for processing my insurance claims. I understand and agree that I am financially responsible for charges not paid by my insurance company, including but not limited to termination of coverage at the time of visit, a non-covered benefit per my insurance plan, or lack of referral from my primary care physician. Copays and Self pays are due at the time of service.

_____ _____
Signature of Patient or Guardian Date

For Medicare Patients Only

I understand that in certain circumstances under Medicare law, Medicare may decide that services are not medically necessary. Since Medicare will deny payment for these services, I agree to be personally responsible for payment of these charges.

_____ _____
Signature of Patient or Guardian Date

PLEASE BRING YOUR INSURANCE CARD FOR US TO PHOTOCOPY.

THERAPY INFORMATION AND BACKGROUND

This information will be held by your therapist and will be considered CONFIDENTIAL.

Please describe briefly your reason for seeking counseling at this time:

When did this situation begin?_____

Have you previously sought counseling assistance? _____

From whom? _____

Please briefly describe that counseling, including its outcomes:

Any family history of:

___Alcohol/drug abuse? ___Sexual abuse? ___Family violence? ___Other problem behavior?

Your History of use of Alcohol and/or other drugs (except for prescribed medications):

Your School and Work History:

Your Spiritual/Religious History: Please include Church attendance and participation:

Your goals for counseling: What would you like your counselor to help you accomplish?

Thank you for filling out this information form before your first meeting with the counselor.