

NEW CLIENT PACKET

Welcome to LifePointe Counseling, LLC and thank you for choosing us for your counseling needs! We are committed to giving you the best possible care and service. To acquaint you further with our policies and procedures we are providing you with the following information. Please carefully read this information before signing at the bottom of each page, then complete all the registration information (pages three and four). If we are billing insurance on your behalf, please be sure to fill out your insurance company name, subscriber name and date of birth, etc. Please ask the front office staff or your counselor if you have any questions.

LifePointe Counseling, LLC is a group of independent medical health professionals, under the name of LifePointe Counseling, LLC. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, we want you to know that the clinician(s) you are seeing here are fully responsible for those services. Their professional records are the property of LifePointe Counseling, LLC; however, no other member of the group can have access to them without your specific written permission. In addition, your provider(s) are solely responsible for matters concerning your clinical care and all questions about that care should be addressed to them.

Appointments: Your time is valuable – and so is your counselor’s. If you need to cancel an appointment, we require a minimum of 24 hours notice so that we can offer your time slot to another waiting client. If you are not able to call and cancel during normal business hours, we do have an automated voice mail system that will record your cancellation message. Simply call us at 314-849-2120 and leave a message on the voice mail system; otherwise, you will be charged a **late cancellation/no show fee of at least \$50 per missed session**. Please note that LifePointe Counseling, LLC does reserve the right to terminate services or deny assistance to any patient who communicates with any staff member in an abusive, profane, threatening or unprofessional manner.

Emergencies: In case of an after-hours emergency, please keep yourself safe and go the nearest emergency room or dial ‘911’ for help. LifePointe Counseling, LLC does not provide emergency services. We do not have 24-hour staff and we are not affiliated with a hospital. Arrangements for after hours or nontraditional services must be discussed and established in writing with your provider. If you need emergency mental health care, please call the Behavioral Response Hotline at 1-800-811-4760.

Financial Responsibility: You are fully responsible for payment of all services provided to you. Full payment is expected at the time of service unless prior arrangements have been made. **Insurance co-pays and co-insurance payments must be paid at the time of service in order to schedule a follow-up appointment.** If your insurance provider changes during the course of your treatment, please contact our medical biller at 314-266-1425 and make sure that your new benefits will help cover our services. Otherwise, significant out-of-pocket expenses may occur.

Please make all checks payable to “LifePointe” or “LifePointe Counseling, LLC”. We also offer payment via credit and debit cards for the majority of our providers (please note an additional 3% is charged with all credit and/or debit payments). Payments made by cash must be made in **exact change**, as no cash money is kept on site. Please note that effective August 1, 2018, any accounts that are sixty (60) days or more past due will be subject to a delinquent fee surcharge as allowed under Missouri law. Past due accounts are subject to 5% interest on the balance after sixty (60) days. Should your account become delinquent beyond 60 days, you will no longer be able to schedule an appointment or receive prescription refills. For details on our financial policies, please see the front 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”.

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

Client/Guardian Signature

Date

LifePointe Counseling, LLC

Healing Hearts ✦ Restoring Hope

If any payments are made by check and returned as “non-sufficient” your account will be billed a \$40 charge for banking fees and re-processing of your claim. At any time, if you have questions about your billing, please call our medical biller at 314-266-1425. We are only able to discuss your account with you, your guarantor, or your insurance company due to medical privacy laws. **Should any of your accounts at LifePointe Counseling, LLC become delinquent beyond 60 days, you will no longer be able to schedule an appointment or receive prescription refills.** If any of these financial procedures present a problem for you or your treatment, please discuss your concerns with your LifePointe Provider or Office Staff.

Insurance Billing: LifePointe submits insurance claims to in-network 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 for you to submit to your insurance for out-of-network reimbursement.

If you see a counselor or doctor here at LifePointe Counseling, LLC that is contracted with your insurance provider, we will be happy to bill your insurance on your behalf. You will still owe your co-pay at the time of service. **We also strongly recommend that you know and verify all your benefits; specifically, your co-pays/co-insurance, deductibles, authorization requirements, etc., prior to your first visit.** We cannot emphasize enough how important this can be in light of the ever-changing health care laws and insurance policy changes we all contend with today.

If your insurance coverage/plan changes, you must contact us with this information prior to your next scheduled visit so that we can both be sure your 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 the insurance company(ies) quotation of benefits is not a guarantee of payment and you are responsible for any fees/services rejected 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. We are obligated to release certain information to get claims processed by your insurance company. Please talk to our office manager if you have any further questions.

LifePointe Counseling, LLC providers do not have an encrypted email or intranet system. Text messages are managed and stored in remote servers for a time by most wireless service providers. Therefore, most communication via email, text, skype, etc. is 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 clinicians 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 in order to send information remotely.

Contact Information: It is vital that you keep your contact information up-to-date with our office. 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 for an Initial Diagnostic Evaluation is not a guarantee that future medication management and/or therapy services will be provided. I understand that the first few sessions with my Provider are a time for both the provider and patient to discuss and assess the issues that the patient wants to address. During this time both parties will also determine whether or not 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

~ Patient Information ~

1. Patient Name _____
(Last) (First) (Middle Initial) (Nickname)
2. Full 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. # (Tricare Clients Only): _____
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) **** Please note LifePointe does not do Out-Of-Network billing ****
2. *Primary Insurance Co. Name: _____ Claims Phone #: _____
Insurance Claims Address: _____
3. Subscriber's Name: _____ 4. Relation to Patient: Self Spouse Parent Other _____
Employer: _____ Subscriber SSN: (Tricare clients only) _____
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 Patient: Self Spouse Parent Other _____
Employer: _____ Work Phone: () _____
11. Member ID # _____ 12. Group ID # _____ 13. 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 homepage, selecting "FORMS", 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:

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)
