**Tiffanie A. Thompson, LCSW**
CityCare Counseling, Inc.
10845 Harney Street, Suite 200
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# Client Information and Consent Form

Personal Information:

Patient's Name _____ Birth date: _____ M/F ___ Starting date: _____

Address: _____ City: _____ State: NE Zip _____

Home Phone: _____ work/cell _____ Patient's SSN: _____ Medicaid# _____

Employed by: _____ Occupation: _____ Marital Status: _____

Who referred you or how did you hear about us? _____

Person Responsible For This Account:

Name of Insured _____ Insured's DOB ____/____/____ SS# ____-____-____ Insured's sex M / F

Insured's Address _____ Phone: _____ Patient's relationship to insured _____Coverage began _____

Insurance Information

PRIMARY insurance Name/Address: _____Phone #: _____
Name of the subscriber: _____ Birth date: _____
ID# _____ GROUP # _____ Employer_____

If you have no insurance, how do you plan to handle payment of your account? _____
_____

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*I _____, agree and consent to participate in behavioral health care services offered and provided at/by CityCare Counseling, a behavioral health care provider. I understand that I am consenting and agreeing only to those services the above provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of the license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. (3) Confidentiality has limitations,(i.e. in the case of abuse and/or neglect, suicide ideation, and threatening danger to others), as well compliance to the subpoena of records from a judge.*

*If the patient is under the age of nineteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.*

*I will be responsible for all expenses incidental to treatment not paid under this plan.*

Client signature: _____ Date _____

Guardian (if required) _____ Witness: _____

* If you need to reschedule your appointment, please call as early as possible, but no later than 24 hours prior or you may be subject to late cancellations/missed appointment charges. Thank you.

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# ASSIGNMENT OF BENEFITS AGREEMENT

CityCare Counseling will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your mental health benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we will complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment. *Please initial x*_____
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. *Please initial x*_____
- We require you to pay the co-payment, which is the amount not covered by your insurance company. You either pay that amount at the time of service or you will be sent a bill for the amount owed. *Please initial x*_____
- Our office does not guarantee that your insurance company will pay for the service you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time. *Please initial x*_____
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. *Please initial x*_____
- We require you to reschedule your appointment no later than 24 hours prior to the appointment. You are subject to charges of $25 for cancelling an appointment with less than 24 hours notice and $50 for missed appointments without notification. *Please initial x*_____

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MENTAL HEALTH BENEFITS DIRECTLY TO CITYCARE COUNSELING.

_____ _____
Signature of Patient/Responsible Party Date