CHANGING LANES CHRISTIAN WELLNESS MINISTRIES & COUNSELING CENTER
650 Sun Temple Drive*Madison, AL*35758
Office Phone: (256) 684-2462 * Office Fax: (256) 325-0084

Sandra Griffin, LPC Grace Crawford, LPC Teresa Cargile, LPC
Reuben Griffin, CPASTC

PATIENT REGISTRATION FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____Work #: _____

Employer Name: _____ Marital Status: Single Married Divorced Widowed

Legal Guardian/Responsible Party Information (If patient is less than 18 years old)

Legal Guardian/ Responsible Party is Patient: ☐ Yes ☐No If "Yes" **skip to next section**

If "No" relationship to Patient: _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____State: _____ Zip: _____

Home #: _____Cell #: _____Work #: _____

Patient/ Guardian signature: _____ Date: _____

FINANCIAL AND POLICY HOLDER INFORMATION

Primary Insurance Information:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Date of Birth: _____ Relationship to Patient: _____

Policy Holder Street Address: _____

City: _____State: _____Zip: _____

Policy Holder Phone #: _____ Sex: ☐ Male ☐Female ☐Other

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Secondary Insurance Information:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Date of Birth: _____ Relationship to Patient: _____

Policy Holder Street Address: _____

City: _____State: _____Zip: _____

Policy Holder Phone #: _____ Sex: ☐ Male ☐Female ☐Other

ADDITIONAL FINANCIAL AND PAYMENT POLICIES

Our policy is full payment at the time services are rendered. We accept most forms of payment. There will be a $30 service charge for NSF or returned check.

We require a **24-Hour notice for cancellation.** We will attempt to make a reminder call or text the business day before your appointment.

_____ For late cancellations, **you will be charged $50**. ***unless stated otherwise by provider**
(Initials)

_____ For No Shows, **you will be charged $50**. ***unless stated otherwise by provider**
(Initials)

Your insurance card(s) may be copied each time you are seen. We must verify correct insurance information at each visit.

Benefits quoted by your insurance company are NOT a guarantee of payment. **You will be required to pay any charges not paid by your insurance company.**

We bill your insurance as a courtesy. If you disagree with any amount your insurance pays or they do not pay, you are responsible for the terms of that agreement.

Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement.

You are responsible for confirming with your insurance company that the providers you are seeing are in your network. **This office does not file claims out of network unless it is approved prior to your visit**.

***This office is not a Medicare/Medicaid Provider now, but we will gladly provide you with the necessary forms to file for reimbursement.**

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*You may be billed for letters or forms completed by your provider. Fees may vary.

We will gladly file your primary insurance for you; however, we will provide you with a completely itemized statement in order for you to file your secondary insurance unless the primary & secondary are both BlueCross BlueShield.

It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for additional attorney or collection fees. If you are covered by managed care you may be exempt from payment of charges not fully covered by your insurance.

I authorize **CLCWMCC** to file insurance for me and to provide the insurance company any information necessary. I further authorize payment to be made directly to my provider at **CLCWMCC**.

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered. I agree to be liable for any costs incurred in the collection of any unpaid balance, including any and all reasonable attorney fees.

I authorize my provider at **CLCWMCC** to release any medical and/or psychiatric information acquired in the course of my examination or treatment to my health insurance company to facilitate payment for medical services rendered. I authorize payment of medical benefits to my provider at **CLCWMCC**.

PRIVATE PAY OPTIONS/FEE FOR SERVICES

New Patient Therapy Intake	**$200.00 *unless stated otherwise by provider**
Follow-up Therapy Session	**$150.00 *unless stated otherwise by provider**

ALL sessions are per 55 mins but can go over depending on the patient's needs.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Clinician/Provider. I understand that I am financially responsible for any balance due. I also authorize CLCWMCC or any insurance company to release the information required to process my claims for payment.

Patient/ Guardian signature_____ **Date** _____

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AUTHORIZATION/PERMISSION TO CONTACT PATIENT

Should a circumstance arise when it becomes necessary for the office to call you for any reason (such as to verify or change your appointment), every effort will be made to notify you in a timely manner. Please indicate your preference for being contacted.

1. Telephone my home ☐ Yes ☐ No home# _____
2. Telephone my place of employment ☐ Yes ☐ No work #_____
3. Email Contact ☐ Yes ☐ No email _____
4. Text message ☐ Yes ☐ No cell # _____
5. Cell Phone Carrier _____

After 3 unsuccessful attempts to contact you in the manner indicated above, we will write a letter addressed to you asking that you contact the office.

EMERGENCY CONTACT INFORMATION

First Name: _____ Last Name: _____

Street Address: _____

City: _____State: _____ Zip: _____

Home #: _____Cell #: _____Work #: _____

Relationship to patient: _____

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

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EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about reportable abuse, neglect, or exploitation of a minor
- The client discloses information about reportable abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or intern, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.
- I understand this consent will be valid for any psychiatrist, psychologist, nurse practitioner, and/or counselor I see during the course of treatment.

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Prior Authorizations (PA's):

- At this time, there is no charge for PA's for medications and other treatments, SUCH AS ADDITIONAL office visits, though many medical offices do charge for this service.
- However, please be aware, as regular insurances continue to increase the burden of such requirements for both patients to receive care, and offices to provide routine care, a charge for this service may become necessary.
- We cannot guarantee that any prior authorization will be approved.

Worker's compensation claims are not done by providers in our office.

All fees subject to change without prior written notice.

Having read the above, I agree to abide by the policies and fees set by **CLCWMCC**. My signature below confirms my reading and understanding ALL Office Policies, Procedures and Fees.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature **(CLCWMCC Staff)** Date

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Patient Rights and Responsibilities

Patients have the right to:

- Be treated with respect and dignity.
- Have their cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
- Receive quality treatment from trained individuals, regardless of race, creed, sex, or national origin.
- Receive treatment in the least restrictive environment.
- Be informed about their diagnosis, treatment, prognosis, and any recommended treatments in terms that they can understand.
- Make informed decisions regarding their treatment.
- Refuse treatment.
- Receive treatment in an environment that is safe and secure.
- Privacy and confidentiality.
- Access information contained in their medical record, according to federal privacy laws, unless clinically contraindicated.
- Be informed of any rules and regulations governing CLCWMCC which affect them.
- Access the Quality Improvement Officer to voice and receive aide in resolving concerns, conflicts, grievances, and/or complaints.
- File a complaint with the appropriate state regulatory agency.

Patients are responsible to:

- Inform their provider to the best of their knowledge, complete and accurate information regarding their medical history, including present symptoms, past illnesses, medications, both prescription and non-prescription, hospitalizations, etc., and to report any changes in their health or in the medication they take.
- Accept consequences should they refuse treatment or not follow the recommendations of the treating professional.
- Ask questions of their provider, or as applicable, CLCWMCC staff when they are unclear about any aspect of their treatment.
- Be considerate of the rights of, and treat respectfully, other patients and staff.
- Take an active part in planning, implementing, and following through with their treatment program.
- Provide adequate notice in the event they are unable to attend a scheduled appointment.
- Notify their network provider if they choose to discontinue their treatment.
- Follow the rules of the program in which they are participating.
- Meet financial commitments agreed to with their network provider.
- Protect the confidentiality of other patients by not disclosing their names or any other information disclosed by other patients.

ACKNOWLEDGEMENT OF RECIEPT

Your signature acknowledges that you have received a copy of the Patient Rights & Responsibilities.

Patient Name: _____

Patient Signature or Patient Representative: _____

Relationship to patient: _____

Date Signed: _____