COMPASS COUNSELING, LLC 3466 B Stellhorn Road, Fort Wayne, IN 46815
260.485.6001 / www.compasscounselingllc.com

CLIENT INFORMATION FORM Date: _____

Client Name: _____ DOB: _____ Sex M/F

Address:_____City:_____State:_____Zip:_____

Spouse's Name: _____ DOB:_____

Marital Status: _____ Years Married: _____ 1st Marriage: Y_____ N_____

Cell: (____)_____ Work : (____)_____

Would you like to receive appointment reminders via **text message**? Y_____N_____ via **email**? Y____ N____

It is our standard office procedure to email receipts and statements. **Initial here for your consent:** _____

Email Address:_____

EMERGENCY CONTACT: _____Relationship:_____Phone: (____) _____

Employer: _____Occupation:_____

Church you attend: _____ Pastor/Priest: _____

List names, ages, and relationship to all members living in household other than client or spouse:

Name: _____Age:_____Relationship:_____

Name: _____Age:_____Relationship:_____

Name: _____Age:_____Relationship:_____

Name: _____Age:_____Relationship:_____

<u>Complete Only if Client is a MINOR:</u>

Natural Father: _____
Name (Last, First, MI)

_____
Address

_____
City State Zip

Phone_____

_____
Date of Birth

Natural Mother:_____
Name (Last, First, MI)

_____
Address

_____
City State Zip

Phone_____

_____
Date of Birth

Legal Guardian: _____Relationship:_____

What has occurred recently that resulted in seeking help today?

_____
_____
_____
_____

How did you hear about us? _____

Have you had previous counseling or psychotherapy? Yes No

Name of Counselor (s)_____

Current physical conditions (medications, health problems, recent surgery, etc.):

_____
_____
_____

Family Stressors - dates of deaths and relationship, divorce, remarriage, illnesses, foster placements, history of abuse/neglect, family conflict or violence, who was involved, other:

_____
_____
_____
_____

Problems at school/work (attendance, relationship with peers, supervisor, or teacher, change in quality of work or grades):

_____
_____
_____
_____

Anything else you would like your counselor to know about your present situation:

_____
_____
_____
_____

FINANCIAL INFORMATION

Person responsible for payment (check one): Same a Client: ___ Other: ____

If other: Name_____

Address:_____ Phone: (____)_____

I hereby give Compass Counseling, LLC consent to:

1. Verify mental health insurance benefits and file claims.
2. Provide my insurance carrier with necessary information including name, diagnosis, prognosis, and treatment information as needed. I also authorize my insurance to pay medical benefits directly to Compass Counseling, LLC
3. To charge my credit/debit card for authorized services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Signature of Client/Guardian Date

Name of Insurance Company*_____

*Please provide your current insurance card

Permission to Treat/Financial Agreement

I hereby give my consent for Compass Counseling, LLC to evaluate, counsel, and treat me and/or my family members. I agree to pay Compass Counseling, LLC in full for services rendered, for charges that are assigned for appointments not kept or late cancellations, and for service fees for past due accounts. I agree to also pay for any medical records copying fees. In addition, I agree to pay for any charges incurred in collection and said debt, including collection agency fees, attorney fees, and court fees. I understand that I am responsible for payment at the time services are rendered. Other payment arrangements are to be discussed prior to services being provided. I understand that I am responsible for insurance co-payments and deductibles, as well as any unpaid insurance balance. Which includes but not limited to: Initial diagnostic evaluation, each 53+ minute sesion and any release of clinical summary.

_____ _____

Signature of Client/Guardian Date

Client Commitment

I acknowledge that I/We have received, reviewed, and understood the information presented on this page.
I agree to abide by the terms disclosed in these documents.

_____ _____

Signature of Client/Guardian Date

CLIENT CONSENT FORMS

COMPASS COUNSELING, LLC has been established to provide individual, couples and family therapy. We are please to have the opportunity to serve you. Feel free to ask questions at any time.

Informed Consent

As a part of our commitment to provide you with the highest standard of care, this section is designed to give you the information needed to make an informed decision about beginning the counseling process.

1. An understanding of our purpose.
2. An understanding that counseling is a partnership between counselor and client. It requires active participation from both to have a higher favorability outcome and in many cases, depending upon the issues being addressed, stress levels may get worse before they get better. In most cases, clients report great improvement as a result of the counseling process, but it cannot be guaranteed. We will do everything ethically possible to be a part of this improvement process.
3. An understanding of the limits mandated by law of confidentiality (see confidentiality section).
4. An understanding that we work in areas in which we have been specially trained and receive continued education.
5. An understanding that we have an ethical responsibility to only work with someone as long as he/she reports progress. If the counseling process ceases to be beneficial to you, steps need to be taken to either correct the problem or end counseling. This will be part of the overall evaluation and goal setting process done throughout counseling.

Confidentiality and Client Rights

Clients are assured confidentiality, which is protected by the law and standards of ethical practice. There are, however, important exceptions to confidentiality that are mandated by law. In general terms the exceptions include:

1. Notifying relevant others if it is assessed that a client has intention to harm him/herself or someone else.
2. Reporting any incidence of suspected child abuse (physical, sexual or neglect). Cases, in which adults have been abused in the past as children, are not required to be reported.
3. Releasing a copy of any records that have been court ordered.
4. Releasing information to the federal government mandated as part of the Patriot Act of 2001. Specific mandates of this act would prohibit our organization from making you aware that such information has been requested.

Release of Information

It is our commitment to hold your right to confidentiality in highest regard. Because of this, we must obtain your consent to use any or all of the following means of exchange of information, should it become necessary to do so. (1) Fax (2) Phone (3) Electronic (4) Mail Correspondence (5) Supervision with psychologist.

Only information that has originated from this office can be released. Third party information (records in the files that came from another source – for example, a doctor's office or school) must be obtained, if needed, from its original source.

Initials _____

(continued)

Client Right to Information

You, the client, have a legal right to information in your file. This includes dates of service, diagnosis, treatment plan, summary and testing summary information. Information that is considered to be "a work in progress" (i.e., session progress notes, raw data from testing) is not held to the same legal requirement. Session progress notes can, however, be released to a client if requested in writing and deemed appropriate by the counselor.

If a client requests information, the treating counselor may request to review the information together with the client as a matter of ethical responsibility. This helps give clients the opportunity to ask questions and gain a full understanding of the nature of the information. This review time between counselor and client will be billed at the rate of $145.00 per hour and generally is not covered by insurance.

Clients Who Are Dependents

If you are requesting services as a parent or guardian of a minor or dependent adult, the same general practice as stated above applies. However, it is important that your child be able to completely trust his or her counselor. As such, we must keep confidential that which your child has requested. Exceptions are the same as stated above. As a parent or guardian, you have the right and responsibility to question and understand the nature of our activity and progress with your child. Given that our goal is to unite families, disclosure of such confidential information usually occurs at some point in the therapeutic process, but the timing is to be agreed upon by the child and counselor and is crucial to the counseling process.

Record Keeping

Indiana law requires that records be kept for seven (7) years from date a client was last seen. For minor children, the law requires that all records be kept seven (7) years after the child has reached his/her 18th birthday.

Messages

As we work together, you will notice that our counselors seldom accept phone calls while in a session with a client. Our phone, however, is answered 24 hours a day, 7 days a week, by either a receptionist or our confidential voicemail system. We ask that you leave a message on our voicemail. Calls made after 5 p.m. Monday-Thursday, on Fridays or holidays will generally be returned the next business day. If you deem your call to be of an emergency nature, our voice mail system will direct you to a number that will provide you with immediate assistance or you may call 911.

Initials_____

Appointments and Cancelation Policies

Our services are by appointment only and are available as scheduling permits. Because appointment times are held specifically for you, it is important for you to keep each appointment. If, for some reason, you do need to cancel an appointment, we ask that you give at least 24 hours' notice so that we can make that time available to others on a waiting list. **IMPORTANT: IF YOU *MISS AN APPOINTMENT* OR *CANCEL WITH LESS THAN 24 HOURS NOTICE,* there is a $35.00 FEE. This fee is *NOT COVERED* under your insurance plan and THE CREDIT CARD ON FILE WILL BE AUTOMATICALLY BILLED.**

Fees and Charges

We believe that a clear understanding of our fees and financial policies is important. With this in mind, the following is presented.

1. **All payments are due at the time of servie.** If you have insurance, your payment will be based on your co -payment amount or your deductible. **However, if for some reason your insurance company doe not pay what was quoted or anticipated, you are still responsible for the entire fee.** In general, we will file all necessary paperwork for you once you have given us permission to do so.
2. Time spent in telephone consultations outside of appointment times and in writing letters will be charged at a pro-rated fee in 15 minute increments. The fee for this service is not typically covered under insurance plans.
3. Court time is charged at a rate of $150.00 per hour. Included in this rate is court time, travel time, preparation time, and in-court waiting time. A two-hour minimum deposit must be made in advance and your account will be refunded or balance billed for the remainder.
4. 90 day overdue accounts will be assessed a late fee rate of 2% per month.
5. Copying fees for medical records are: $15.00 for pages 1-10 and $.25 for each additional page.
6. Compass Counseling, LLC reserves the right to add the cost of fees incurred (such as collection fees, attorney fees, court costs, etc.) as a result of pursuing outstanding balance to any overdue account. We will also waive any reduced fee rate.
7. A $30.00 fee will be charged for any check returned for non-sufficient funds.

I have read, understood, initialed where necessary, and agree to abide by the terms set forth in this document.

_____ _____ _____

Signature of Client/Guardian **Date** **Initials**

(Continued)

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Fort Wayne, Indiana 46815

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PRIVACY NOTICE ACKNOWLEDGEMENT

The undersigned acknowledges receipt from Compass Counseling, LLC of its Notice of Privacy Practices.

_____	_____	_____
Patient Name (print)	Signature of Client/Guardian	Date

If Client is a Minor Complete This Section

Please list the names and dates of birth for the children/minor dependents you are signing for:

Names:	**Dates of Birth:**
_____	_____
_____	_____
_____	_____
_____	_____