WISDOM TRADITIONS
–COUNSELING SERVICES, LLC–

Patient Intake Form

Patient Name: _____ DOB: _____

Gender _____ Marital Status _____ Social Security # _____/_____/_____

Ethnicity: ☐ American Indian ☐ Alaska Native ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic or Latino ☐ Other

Phone Home # _____ Cell #_____ Work # _____

May we leave a detailed message? Yes No

How would you like your reminders? Text Call Email

Email Address: _____ ☐ Join Online Patient Portal

Mailing Address: _____

Physical Address: _____

City_____ State_____ Zip Code _____

Occupation: _____ Employer _____ ☐ Full Time ☐ Part Time

Employer Address _____ Zip _____

Emergency Contact: _____ Relationship: _____

Home Phone # _____ Cell # _____

Whom may we thank for referring you to us? _____

- I have received and reviewed a copy of: FAQS & Waiver of Liability
- I have received and reviewed a copy of Standards of Confidentiality of Patient Records under the Health Insurance Portability and Accountability Act (HIPPA, 45 CFR).
- I have received and reviewed a copy of the Licensed Professional Counselor Disclosure Statement and Counselor Disclosure statement.
- I consent to the treatment which may be initiated during this visit and for ongoing treatment as a patient of Wisdom Traditions Counseling Services, LLC.
- If patient is a minor, I hereby authorize treatment

Patient/Guardian Signature: **Date:**

Staff Witness: **Date:**

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Patient Notice of Confidentiality

The confidentiality of alcohol and drug abuse patient records maintained by Wisdom Traditions Counseling Services and Recovery Program is protected by federal and state law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuse UNLESS:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

References for laws and regulations:

42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws.

42 CFR part 2 for federal regulations.

I have received and read the above Patient Notice. I have also received and read the Notice of Privacy Practices, which delineates my rights in regards to my Protected Health Information under the federal Health Insurance Portability and Accountability Act (1996).

I have also received the Recovery Program Patient Expectations and Guidelines which outlines my rights as a patient, the rules of the program and emergency safety procedures.

Patient Signature: **Date:**

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Insurance Assignment of Benefits/Insurance Release Form

Patient Name: _____ **DOB**:_____

Primary Ins: _____ Effective Date: _____

Policy Holder: _____ Relationship: _____

SS#: _____ Date of Birth: _____

Employer: _____ Group#: _____

ID#:_____ Contract #: _____

Secondary Ins: _____ Effective Date: _____

Policy Holder: _____ Relationship: _____

SS#: _____ Date of Birth: _____

Employer: _____ Group#: _____

ID#:_____ Contract #: _____

Patient or Guardian, please initial:

_____ I understand that my insurance company will be billed at the full cost for service.

___ Patient is not covered under any health care plan.

___ Patient has insurance, but does not wish services to be billed to them. This constitutes FULL FEE FOR SERVICES.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Wisdom Traditions Counseling Services, LLC for any charges not covered by health care benefits. It is my responsibility to notify Wisdom Traditions Counseling Services, LLC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Wisdom Traditions Counseling Services, LLC and/or my insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment of services and/or treatment provided.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits to Wisdom Traditions Counseling Services, LLC for all covered services provided to me during all courses of treatment and care provided. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by Wisdom Traditions Counseling Services, LLC, and will constitute a continuing authorization of any insurance policy that is in effect at the time of service, maintained on file with Wisdom Traditions Counseling Services, LLC, which will authorize and allow for direct payment to Wisdom Traditions Counseling Services, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, and care provided.

Patient (Guardian)/Insured (Printed): **DOB:**

Patient (Guardian)/Insured (Signature): **Date:**

I authorize Wisdom Traditions Counseling Services, LLC to release information from the medical records of the above-mentioned patient for the purpose of accessing insurance benefits. This information may include diagnoses and dates and type of treatment received. Additional information may be requested before claim payment is made and may include, but not limited to, items such as the intake report, treatment plan, progress notes, medications prescribed, and discharge report.

Patient (Guardian)/Insured (Signature): **Date:**

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Financial Policy & Payment Plan

Our standard financial policy is to accept payment in full prior to time of service. This includes cash patients, as well as all patients who are subject to co-pays and deductibles. We will bill your insurance as a COURTESY. However, should your insurance not cover a prior date of service for any reason, we will notify you and send you a statement for the amount due.

By signing this you agree that you are financially responsible for any outstanding balance(s), payable in full no more than 30 days from the date of formal written notification by our office.

Should you fall behind on your agreed payment arrangements we may ask you to suspend your group attendance until your account balance is current. We understand financial needs, and will do our best to work with each patient on an individual basis, should financial arrangements be necessary. If circumstances prevent you from making a full payment at the time of service, please notify us immediately so we can discuss the possibility of payment arrangements. Should payment arrangements be necessary we ask that you provide us with a credit card on file.

Please be aware of these additional charges that may result from outstanding balances, no-show fees and over-draft check charges.

_____Initial All balances over 90 days, are subject to the following fees:
$15.00 monthly charge on all accounts less than $200
$29.00 monthly charge for all accounts balanced $200 or more

_____Initial $55.00 No Show Fee for individual counseling session without 24 hour prior cancellation

_____Initial $35.00 Over-draft charge for any check that is returned for non-sufficient funds (NSF)
And we will no longer accept checks from anyone who has such a charge.

_____Initial I understand that I must pay my co-pay, or if uninsured payment in full, at each visit.

By signing this you agree to adhere to all financial arrangements made with Wisdom Traditions, and any default of such arrangement without prior notification or amendment, will result in suspension from group attendance and your account will become Payable in Full.

We appreciate your cooperation and understanding.

I have read, understand and agree to the above policy terms and conditions.

Patient Name (Printed)_____ **Date**_____

Patient Signature _____

Staff Witness _____ **Date**_____

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Consent for Release of Confidential Information

(One agency or individual per form)

I, _____DOB_____ authorize **Wisdom Traditions Counseling Services**

(Please Print Name)

To exchange information with:

_____ _____

(**Name of Agency, Individual or Self**) (**Address, Phone or Fax Number**)

With regards to:

_____

(Examples: Assessment results, attendance, compliance with treatment, financial status of account, all records

I authorize the administrative, program and clinical staff of Wisdom Traditions to use this information, and/or disclose this protected health information. If the records pertain to alcohol and/or drug treatment, I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. I understand that records pertaining to medical information and/or Mental Health services records are covered by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my consent unless otherwise provided for in the regulations. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken in reliance on it.

I understand that generally Wisdom Traditions Counseling Services may not condition my services/treatment information on whether I sign this consent form.

_____

(Patient Signature) **(Date)**

_____

(Staff Witness) **(Date of Expiration)**

_____

Signature of parent, guardian or authorized representative

(Description of Authorized Representative Authority)