EAGLE CONSULTING
COUNSELING DIVISION
making a life difference

General Client Information

First Name:	Middle:	Last:	
Email:	DOB:	Age:	M ☐ F ☐
Address:			
City:	State:	Zip:	SS#
Home Phone:	Cell:	Work:	
Employer:	Job Title:		
Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐			
Referred by:			
How did you hear about us?			

Emergency Contact Information

Name:	Home #:	Work #:	Cell#:
Relationship:	Guardian's Name:		Cell#:

Contact Information

As a courtesy, we will attempt to contact you to remind you of upcoming appointments. Please check the appropriate line below to indicate your preferred method of notification and include contact information.

☐ **TEXT MESSAGE**	Phone number:
☐**PHONE CALL**	Phone number:
☐**EMAIL**	Email address:

I understand that communication may arise through electronic communication (text, email, cell phone) and it is not a secure means of communication. I am aware that Eagle Counseling may decline to communicate via electronic communication based upon the nature of the medical information. We are not responsible for misaddressed, misdelivered, or interrupted email nor or we liable for breaches of confidentiality caused by yourself or a third party. Time sensitive issues should be taken care of by telephone. I give permission for Eagle Counseling to use electronic communication with me.

_____ _____

Signature of Client or Responsible Party Date

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Cancellation Policy:

All appointments must be cancelled **24 HOURS** prior to the scheduled session time. Failure to cancel within this time frame will result in the charges listed:

No Charge for first occurrence; **$25** for second occurrence; **$50** for all other occurrences

No Show Policy:

- Clients who do not attend scheduled appointments will be charged a **$50 No Show Fee** .
- If a late cancellation or no show fee is charged to the account, the client is responsible for the balance before rescheduling.
- In the event that a client has services under an Employee Assistance Program or Managed Care, the cancellation or no show fee will be charged to the client and not the benefit program.

I have read and understand the **Late Cancellation** and **No Show** fee policy as explained and described in this statement. I agree to adhere to the policy and will be held responsible for the information contained in it.

_____ _____

Signature of Client or Responsible Party Date

Counseling Agreement

Confidentiality Statement

As a client, visitor, guest, or student at Eagle Consulting, I understand that Federal Regulations on confidentiality require that I do not reveal the identity of any person I may see while at Eagle Consulting. I understand that any disclosure of patient information, including the person's presence in treatment, or description of any person without specific written consent from that person may be interpreted as a Federal Criminal Offense.

I agree to maintain patients' confidentiality at Eagle Consulting. Any request for information will be turned over to the director who will release such information within policy guidelines of Eagle Consulting.

I maintain the confidentiality of those receiving care at Eagle Consulting in order to facilitate a safe and secure environment for treatment and health for others and myself.

_____ _____

Signature of client, visitor, guest, or student Date

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Confidentiality of Client Records

Federal law protects the confidentiality of client records maintained by this program. Generally, the program may not say to a person outside Eagle Consulting that a client attends the center, or disclose any information identifying a person as a client of Eagle Consulting unless:

1. The client or parent of a minor consent in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical emergency.
4. The disclosure is about suspected child abuse or neglect.
5. The disclosure is regarding behavior that places the client or others in jeopardy while working in what the counselor can reasonably assume to be a safety sensitive position.

I have read and understand the limitations of confidentiality and release of information as explained and described in this statement.

_____ _____

Signature of client and guardian Date

Consent Agreement

I hereby grant permission for any counseling, counseling observation, or diagnostic evaluation that may be deemed pertinent by Eagle Consulting therapists. I understand that counseling sessions for my family, my marriage, or myself are strictly confidential.

_____ _____

Signature of client and guardian Date

Payment Policy

Self Pay

Clients are responsible for all payments at the time of services rendered. Checks, Cash, Visa and MasterCard are accepted.

Easy Pay

Eagle Consulting provides *Easy Pay* to make payment more convenient. ***As an Easy Pay Private Pay client*** *(client paying full session fee)****, you will receive a 5% discount on session fees provided at The EC.*** *Easy Pay* does not apply to resources (such as testing, books, or med clinic) and cannot be combined with any other discounts or rates.

With my signature, I authorize Eagle Consulting to retain my credit/debit card information in their confidential files and automatically charge my debit/credit card at the time of each session, waiving the necessity of individual authorizations. Should I choose to discontinue this method of payment, I will notify Eagle Consulting.

Name on card: _____ _____VISA _____MasterCard

Card Number: _____ Expiration Date: _____

Signature: _____ Date: _____

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Employee Assistance Programs (EAP)/Insurance/Third Party

If clients are attending sessions through an Employee Assistant Program, Insurance, or Third Party, pre-approval is required, and the number of sessions pre-established. For clients attending through insurance, the number of sessions is determined by the number authorized by the insurance company. If the EAP, insurance or third party fails to cover session fees, the balance will revert back to the client for payment.

Insured Parties Information

Insurance Company:		
Insured's First Name:	Middle:	Last:
Insured's SS#		
Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other:		
Insured's Address:		
Insured's Home Phone #:	Work #:	Cell #:
Policy#:	Group#:	
Insured's DOB:	☐M ☐F	
Insured's Employer:		

Billing Consent

With this consent, Eagle Consulting may call my home or other alternative location in reference to any items that assist the practice. This includes such items as insurance questions, questions regarding payment for services, and any and all calls pertaining to clinical care.

In addition, I authorize Eagle Consulting to release to my insurance carrier any information necessary to process claims when I am accessing benefits. This may include a diagnosis and reasons of treatment as well as notes that have been taken of progress.

Insured Signature: _____ **Date**: _____

Responsible Party signature (if different from Insured): _____ Date: _____

Co-Pays

Your co-pay is expected in full at each office visit. We ask that you pay before the appointment for your convenience. This amount has been set by your insurance company and your employer.

Non-Covered Services

Please be aware that some of the services that you receive may not be covered by your insurance or EAP plan. Some of these will include personality profile testing, family contracts, books, phone sessions, med clinic, or correspondence to other providers or agencies. You are responsible for payment of these services.

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HIPPA

For your convenience, a copy of the HIPPA Notice of Privacy Practices is located in the waiting area of Eagle Consulting. If you wish to obtain a copy of this policy please see the front desk and they will be happy to assist you. If you have any questions concerning this policy, please feel free to contact Kim Smith at 256-341-0811.

I, _____, have been notified that a copy of Eagle Consulting's **HIPPA Notice of Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and state law, is located in the waiting area of Eagle Consulting. Also, I understand the contents of the Notification. By law, Eagle Consulting is required to obtain your signature indicating you have read/received the document. Your signature below does not surrender any rights or confidentiality.

SIGNED:_____ Date:_____

Thank you for choosing the Eagle Consulting/Counseling Division.
We recognize that you have a choice when considering counseling providers, and we appreciate your confidence in us. We are pleased to offer the highest quality of therapeutic services to you. In exchange, we appreciate your cooperation with our staff and treatment recommendations. If at any time, you become dissatisfied with the services you are receiving or desire to change a therapist, please discuss these concerns with your therapist and/or the clinical director. We will try to accommodate you when appropriate or assist in referral to another agency.
Thank you again for choosing us to walk through this season with you!
www.counselingtec.com