
# Counseling Appointment Agreement

I consider your (or your child's) treatment plan important to providing the best possible service. In respect to that principle, and also to my time that will be designated to your needs, I expect that all appointments will be kept. ***Please note that a $50 fee may be charged for late cancellations.*** There will be no fee charged if you provide at least one business day's (no less than 24 hours) notice for a cancellation and/or rescheduling of an appointment. *(For example, an appointment on Monday or following a holiday must be cancelled on the previous business day with consideration of the one business day / NLT 24 hours' notice requirement.)* As there are a limited number of appointment slots available, this policy allows us to offer the appointment time to someone else who needs to be seen.

Payment of fees is expected at the time of each appointment unless the session is covered by an insurance plan. Your credit card will be processed at the start of the session, should you need to pay the deductible up front with a credit card. Employee Assistance Program benefits may cover our services, however, we will need to contact the representative at your place of employment first to verify the coverage, deductibles, and any other criteria that must be met.

Please note that your therapy appointments will last for 50 minutes to one hour in length. The initial session, however, may last longer on a case-by-case basis.

Your signature below indicates that you have read, understand and agree to the terms stated above and will continue to force throughout the time that provision of services continue.

**Client/Parent/Guardian Signature** _____ **Date**_____

**Witness Signature** _____ **Date**_____

(Note: The witness above may be your clinician or one of our administrative staff.)

**5401 Kingston Pike, Building 2, Suite 400, Knoxville, TN 37919 • Phone 865-214-7584**

# CLIENT INFORMATION & RELEASE FORM

DX Code(s):

Description:

Therapist's Name: _____

Referral Source: _____

Client's Name: _____
Last First Middle

Address: _____
Street Number & Name (Apt #) City State Zip

Home Phone (____)____-_____ DOB: ___/___/____ SSN: ____ -____-_____

Work Phone (____)____-_____ Cell Phone (____)____-_____

Client's Employer:_____

Emergency Contact Person: _____

Address: _____ Home Phone (____)____-_____

Work Phone (____)____-_____

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single

Client's Gender: ❑ Male ❑ Female

Responsible Party's Name: _____
Last First MI

Address: _____
Street Number & Name (Apt #) City State Zip

Home Phone (____)____-_____ DOB: ___/___/____ SSN: ____ -____-_____

Relationship to the client: _____

Responsible Party's Employer: _____

Responsible Party's Employer's Office Phone: (____)____-_____

Insurance Provider: _____

Insurance policy Number: _____

I give permission for my therapist to collect monies from and communicate directly with my Insurance Company about me.

Signature: _____ Date: _____

Client's Physician's Name: _____ Phone (____)____-_____

Have you ever been treated by a Counselor/Therapist before? ❑ Yes ❑ No

## HOUSEHOLD MEMBERS (Including the client)

| Name | Birth Date/ Age | Employer/ School | Occupation/ Grade | Religious Affiliation | Education Level |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**RESPONSIBLE PARTY:** I understand that I am financially responsible for payment of all charges made during the course of treatment and agree to pay as treatment progresses. Should I default on payment, I understand my balance is subject to collections and I am also responsible for the collections charges.

Signature: _____ Date: _____

**Revised: 05/2014**

# YOUR RIGHTS AND RESPONSIBILITIES

- You have the right to good treatment - to be treated nicely, no matter what your state of mind or condition.
- You have the right to be cared for and not be neglected, abused, have your feelings hurt or be yelled at.
- You have the right to privacy.
- You have the right not to be exploited: That is, your provider cannot use you or your case for her or his own personal gain.
- You have the right to treatment no matter your age, race, sex, religion, ethnic background or handicap. If this provider cannot treat you for any reason, you have the right to be referred to a provider who can and will treat you.
- You have the right to know your diagnosis, how your problems will be treated and what you can expect during the term of treatment.
- You have the right to make choices about your care. If a particular treatment is known to be dangerous, you will be given all the information you need to make a good decision about your treatment.
- You have the right to refuse treatment. If you say, "No", to a particular treatment, you have the right to know what might happen with and without the treatment.
- You have the right to see your records. You have the right to have your records treated confidentially, in accordance with the laws.
- You have the right to plan and help decide the kinds of future mental health care you receive if you get sick and cannot tell someone (for example, living wills, power of attorney, guardianship).
- You have the right to file a complaint/grievance with your provider or the Health Related Boards about your services or care given to you. You cannot get in trouble if you file a truthful complaint/grievance.
- You have the right to treatment in the proper place. You won't be sent to a hospital for inpatient treatment if all you need is a therapist. The best location and level of care will be discussed.
- If you have questions or do not agree with your treatment plan, you should discuss it with your provider.
- You have the responsibility to be on time for all appointments with your provider.
- You have the responsibility to give information to your provider if it's needed for your care.
- You have the responsibility to give your opinions, concerns or complaints about your health care and these rights and responsibilities to your provider.

Signature: _____ Date: _____

# Counseling Connection, Inc.

Clinician's Name: _____

Before you arrive for your first session with your clinician at the Counseling Connection, Inc., you need to read the Privacy page on our website. Also, visit the U.S. Department of Health and Human Services webpage regarding privacy: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html Please take time to read the information presented therein. We also will need acknowledgement of understanding your privacy protection for your record that we maintain here.

## Privacy Protection Acknowledgment Form

I hereby acknowledge reading the Counseling Connection, Inc.'s Privacy page at www.knoxcounseling.com, as well as federal government's web page regarding privacy protection.

Client's Name: _____
Last First Middle

Client's Date of Birth: ___/___/_____ Today's Date: _____/___/_____

Client's Signature: _____ *(See the exception below)

* Exception to the client signature above: If the client is under 18, the parent or legal guardian must be the one to sign this form.

Parent/Legal Guardian's Name:: _____
Last First Middle

Parent/Legal Guardian's Signature:: _____

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**In case of an emergency, change of appointment, or other important information, how may we contact you?**

| | | May we leave a message? | | Client or parent/ legal guardian's initials for each: |
|---|---|---|---|---|
| Home Phone: | (_____) _____-_____ | ❑Yes | ❑No | _____ |
| Cell Phone: | (_____) _____-_____ | ❑Yes | ❑No | _____ |
| Work Phone: | (_____) _____-_____ | ❑Yes | ❑No | _____ |
| Other Phone**: | (_____) _____-_____ | ❑Yes | ❑No | _____ |

** For this phone, please write detailed instructions below (e.g. explain if this is the phone of a friend, neighbor, or relative and other specific information we may need to know when contacting you through them):

# Counseling Connection, Inc.
# Permission to Treat Client

Check here if the client is an adult ❑ Check here if the client is a minor child ❑

Client's Name: _____ Date of Birth: : ____/___/____
Last First MI

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Address: _____
Number & Street City State Zip

If the above-named is a minor child (age under 18), complete this section and sign below.

**PERMISSION TO TREAT MINOR CHILD (Under age 18):** My signature below indicates that I give full permission to treat my minor child.

Parent/Legal Guardian's Name:: _____
Last First Middle

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Address: _____
Number & Street City State Zip

Parent/Legal Guardian's Signature:: _____ Date: ___/___/___

**PERMISSION TO TREAT ADULT CLIENT:** My signature below indicates that I give full legal permission to be treated.

Adult Client Signature: _____ Date: ____/___/____

Witness' Name: _____

Witness' Signature: _____ Date: ____/___/____

Clinician's Name: _____

# Counseling Connection, Inc.

## RELEASE FROM / NOTIFICATION TO PRIMARY CARE PHYSICIAN OR OTHER MEDICAL PROFESSIONAL

## THIS IS NOT A REQUEST FOR MEDICAL RECORDS

To: _____ Phone: (____) _____-_____
Primary Care Physician or Other Medical Professional's Name

Fax: (____) _____-_____ Today's Date: ____/___/_____

Address: _____
Number & Street City State Zip

Re: _____ Date of Birth:___/___/___
Client's Name

From: _____ at Counseling Connection, Inc.
Counseling Connection, Inc. Psychologist/Counselor/Therapist's Name

**Location: 5401 Kingston Pike, Building 2, Suite 400, Knoxville, TN 37919 • Phone 865-214-7584**

**The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program** is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. For more information, please visit the U.S. Department of Health and Human Services website: http://mchb.hrsa.gov/epsdt/

(Counseling Connection, Inc. requests the results of EPSDT screening on minor patients, when available.)

**If you have any pertinent information regarding this person, please forward it to the Psychologist, Counselor, or Therapist at the location listed above. If requested information is more than five (5) pages, please mail rather than fax. Thank you.**

**Initial the following, as appropriate:**

_____I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician indicated above to release the information contained on the form to the clinician/facility identified above. I also consent to other necessary communication between the be behavioral health provider indicated above and the clinician/facility identified above. The purpose for exchanging information is to provide continuity and coordination of care. This agreement is valid for one year. I understand that I may revoke my consent at any time.

I do not wish to have information shared with: _____ My Primary Care Physician/Medical Provider
_____ My other behavioral health clinicians/facilities
_____ I am not currently receiving services from a Primary Care Physician/ other medical practitioner
_____ I am not currently receiving services from any other behavioral health clinician/facility

**Signature** (If child, legal guardian signature): _____ **Date:**_____/___/_____

**Clinician Signature**: _____ **Date:**_____/____/_____

**NOTICE TO PERSON RECEIVING THIS INFORMATION:** The information disclosed as a result of this authorization is released to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR OFFICE USE ONLY:

The patient is being treated for the following diagnoses:

Date Treatment Began: _____/____/_____