



ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

ACKNOWLEDGEMENT OF GUARDIAN/CUSTODIAN

I, (print name) _____, certify that I am the legal guardian/custodian
of (print name): _____.

Signature Date

Witness Date



ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

PATIENT/CLIENT BILL OF RIGHTS, RESPONSIBILITIES, AND THE LIMITS OF CONFIDENTIALITY

Anchor Psychological & Counseling services has a written policy identifying their commitment to delivery of client services in a manner that respects the individual's rights and clearly states the patient's responsibilities.

RIGHTS

Clients have a right to receive information in a clear and concise manner stating the services provided, the practitioners rendering services and knowledge of the treatment plan and options available to them.

1. Clients have a right to expect treatment being rendered with respect, recognition of the dignity and a right to privacy.
2. Clients have a right to participate with the practitioners in determining the most appropriate treatment plan and services, regarding their healthcare.
3. Clients have a right to candid discussions and explanations in decisions related to their treatment and selection/rejection of the most appropriate options, regardless of the cost or benefit of coverage.
4. Clients have a right to voice complaints or request appeals about the services or personnel delivering the services.

RESPONSIBILITIES

Clients have a responsibility to provide, to the extent possible, information needed in order to deliver care with full knowledge of the client's history, current status and other relevant details.

Clients have a responsibility to comply with the treatment plan and instructions for the care they have agreed to with their healthcare providers.

5. Clients have a responsibility to understand their allowances, requirements and limitations of their selected health carriers.
6. Clients are responsible to provide accurate and current information to the practice representative and healthcare providers to permit timely and just coverage for services rendered.

LIMITS OF CONFIDENTIALITY

1. You direct the clinician to tell someone else.
2. The clinician determines that the patient is a danger to themselves or others.
3. The clinician receives information regarding child/elder abuse or neglect.
4. The clinician is ordered by a court to disclose information.
5. If required for insurance billing purposes.

Client/Patient Signature



ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

DATE: _____

RE: _____ DOB _____

Dear _____ Facility _____

This letter is to inform you that I am currently seeing your patient for outpatient psychotherapy services at Anchor Psychological & Counseling Services, PLLC. At this time, a working diagnosis of

has been established. In order to provide the highest level of care, our clinic wishes to establish on-going communication with your facility. Should you have questions or concerns, please feel free to contact me at (910) 270-9995.

Sincerely,

Signature	Printed Name
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I (check one) do do not allow Anchor Psychological Health Services, PLLC and my referral source to have on-going communication in order to provide me with the highest level of care. This form expires 12 months from the date signed unless revoked in writing prior to that date. _____

Client /Parent/ Guardian Signature

Date

Therapist Initials: _____



ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

PATIENT INFORMATION:

PATIENT NAME: _____ SEX: M F AGE: _____ DOB: _____

ADDRESS: _____ SSN: _____ HOME PH: _____

ALT NUMBER: _____ MARITAL STATUS: M S D W STUDENT: Y N NAME OF SCHOOL: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO NAME: _____ POLICY/ID #: _____

GROUP #: _____ INSURANCE PHONE NUMBER: _____ NAME OF SUBSCRIBER: _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO NAME: _____ POLICY/ID #: _____

GROUP #: _____ INSURANCE PHONE NUMBER: _____ NAME OF SUBSCRIBER: _____

RESPONSIBLE PARTY

NAME: _____ ADDRESS: _____ PH: _____

DOB: _____ SSN: _____ REALTIONSHIP TO PATIENT: PARENT/GUARDIAN OTHER SELF

*Health Care insurance is a contract between you and your insurance company. It is the patient's responsibility to know their policies and see that we get the proper referrals prior to visit. **All co-payment amounts are due at the time of service.** You are responsible for deductibles and any applicable expenses your insurance does not cover. By signing this agreement you are allowing this office to release any mental health information necessary to process your claims and to also authorize payment of mental health care to Anchor Psychological & Counseling Services, PLLC for services rendered.*

SIGNATURE: _____ DATE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

ALL NON-TRICARE:

I request that payment of authorized insurance benefits be made on my behalf to Anchor Psychological & Counseling Services, PLLC for any services furnished to me by them. I authorize any holder of medical/psychotherapy information about me to release to the health care finance administration and its agents any information needed to determine these benefits or benefits payable to related services. I authorize my signature requests that payment be made and authorizes release of medical/psychotherapy information necessary to pay the claim. If item 9 of the HCFA-1500 claim for me is completed, my signature authorizes releasing of the information to the insurance or agency shown. Insurance assigned cases, the physician or supplier agrees to accept the charge determination of insurance carriers as the full charge and the patient is responsible only for the deductible, co-insurance(s), and the deductible are based upon the charge determination of the insurance carrier.. Non-covered services require a separate form.

BENEFICIARY AND/ OR PARENT/GUARDIAN SIGNATURE DATE

Tricare- *"I request that payment of authorized benefits be made on my behalf to Anchor Psychological & Counseling Services, PLLC for any services furnished to me by that organization. I authorize any holder of medical/psychotherapy information about me to release to Health Net and its agents any information needed to determine these benefits or the benefits payable for related services."*

BENEFICIARY AND/ OR PARENT/GUARDIAN SIGNATURE DATE

NO SHOW/CANCELLATION FEE: I UNDERSTAND THAT IF I CANNOT KEEP AN APPOINTMENT, I MUST CANCEL TWENTY-FOUR (24) HOURS PRIOR TO THE APPOINTMENT OR I WILL BE CHARGED A "NO SHOW" CHARGE OF FIFTY DOLLARS (\$0.00)

SIGNATURE DATE

WITNESS DATE

CONSENT TO TREAT AGREEMENT:

*******MUST BE SIGNED TO RECEIVE TREATMENT******* BY MY SIGNATURE HEREIN, I AFFIRM THAT I AM THE PATIENT _____ (PARENT/LEGAL GUARDIAN OF) AND I HEREBY ACKNOWLEDGE THAT I AUTHORIZE AND GIVE PERMISSION TO THE STAFF OF ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC, TO RENDER TREATMENT AND/OR SERVICES TO MYSELF/ABOVE NAMED MINOR, AND I HEREBY ACKNOWLEDGE THAT STAFF IS RESPONSIBLE FOR TREATMENT AND/OR SERVICES RENDERED IN THE COURSE OF TREATMENT (THERAPEUTIC TIME IN FACILITY) AND CANNOT BE HELD RESPONSIBLE FOR MY BEHAVIOR/BEHAVIOR OF MINOR CHILD OUTSIDE OF THE CONTEXT OF THE THERAPEUTIC TREATMENT SESSION.

SIGNATURE DATE



ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC

PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

REASON FOR VISIT _____

HAVE YOU SOUGHT TREATMENT FOR THIS PROBLEM BEFORE? _____

IF SO, WHEN? _____ WHERE? _____

WHO REFERRED YOU TO THIS CLINIC? _____ HAVE YOU SOUGHT TREATMENT FOR ANY MENTAL HEALTH/EMOTIONAL PROBLEMS BEFORE? _____ IF SO, PLEASE EXPLAIN _____

PLEASE LIST AND DESCRIBE ANY SIGNIFICANT MEDICAL HISTORY (ILLNESSES, DISEASES, SURGERIES, ALLERGIES, ETC.) _____

PLEASE LIST ANY FAMILY HISTORY OF MENTAL DISORDERS OR MEDICAL CONDITIONS (LIST CONDITION AND HOW RELATED). _____

PLEASE LIST EVERYONE WHO LIVES IN YOUR HOME, THEIR AGES, AND SCHOOL/EMPLOYMENT. _____

WHO IS YOUR PRIMARY CARE DOCTOR/CLINIC? _____

ADDITIONAL RELEVANT INFORMATION: _____