

**Christian Psychological Center
3978 Central Avenue
Memphis, TN 38111-7602**

Information for New Clients of the Christian Psychological Center

Thank you for giving us the opportunity of providing your psychological services. Our goal is to assist you in resolving the concerns that led you to contact Christian Psychological Center. We hope that this information helps you learn more about Christian Psychological Center and the services we provide.

Before your first appointment, please:

- Complete the **Information Sheets**
- Fill out the **Contacting You** page.
- Read through the *Christian Psychological Center Practice Policies* brochure, which outlines important information about our services, policies, and procedures. If you have any questions about this information, please discuss them with your therapist during your first session. If you are in agreement with this information, please sign the Agreement form. The agreement form attached to the actual document is for your records. The second agreement, attached to this section of paperwork, is to be signed by you and kept by our office.
- Our privacy notice, which describes how your mental health records may be used and disclosed and how you can obtain access to this information, is enclosed for your information. Please sign the *Patient Notification of Privacy Rights* document in this section to indicate that you have received this privacy notice. By federal law, we are required to secure your signature on this document indicating that you have received this information.

A few minutes of the initial appointment will be spent discussing the enclosed information with your therapist. This will give you the opportunity to ask any questions about the Center or the services you will be receiving.

PLEASE COMPLETE ALL REQUESTED INFORMATION

CHRISTIAN PSYCHOLOGICAL CENTER
Information Sheet

Chart # _____

Date _____

Therapist _____

CLIENT'S (PATIENT) PERSONAL INFORMATION

(Legal Name) Last Name _____ First Name _____ MI _____

Preferred Name _____ Home Telephone: () _____

Street Address _____ Apartment # _____

City _____ State _____ Zip Code _____ Cell Telephone: () _____

Date of Birth _____ Age _____ Sex _____ Social Security Number _____

Marital Status: Single Married (Spouse's Name: _____) Divorced Widow(er)

Referred By _____

(EX: Church/Name; Internet; Insurance Co./Name; Medical Doctor/Name; Previous Patient; School/Name; Word-of-Mouth; Other/Please Specify)

Church Name _____

Person to Notify in Case of Emergency _____

Telephone Number(s): () _____ Relationship to Client _____

CLIENT'S (PATIENT) EMPLOYMENT INFORMATION **(CHILD'S SCHOOL INFORMATION)**

Employer _____ Employer Telephone: () _____

Employer Address _____ Suite # _____

City _____ State _____ Zip Code _____

Child's School, City & State _____ Grade _____

PERSON RESPONSIBLE FOR PAYMENT

Last Name _____ First Name _____ MI _____

Relationship to Client _____ Date of Birth: _____

Social Security Number: _____

Telephone/Home () _____ Work () _____ Cell () _____

Responsible Party Address: _____

City _____ State _____ Zip Code _____

Name & Address of Responsible Party's Employment:

IF CLIENT IS UNDER 18 YEARS OF AGE OR IF PARENT(S) IS RESPONSIBLE FOR PAYMENT, COMPLETE THIS SECTION

Parent's Marital Status Married Divorced Single Widowed

Mother's Name _____ Telephone/Home () _____ Cell () _____

Address _____ City _____ State _____ Zip _____

Mother's Employment _____ Work Telephone () _____

Father's Name _____ Telephone/Home () _____ Cell () _____

Address _____ City _____ State _____ Zip _____

Father's Employment _____ Work Telephone: () _____

If divorced, have parents remarried? Mother _____ Father _____

Name of the custodial/primary residential party? _____

If step-parents, please furnish names: Step-Mother: _____ Step-Father: _____

Insurance Information

Primary

Insurance _____

Address _____ City _____ State _____ Zip _____

Telephone: () _____ ID/Certificate/SS/Member Number: _____

Group # _____ Policyholder Name: _____

Relationship to Patient: Self Parent Spouse Other (*Please Indicate Relationship:* _____)

Policyholder's Date of Birth: _____ Co-Pay Amount: \$ _____ Deductible Amount: \$ _____

Insurance Effective Date(s): _____ Precertification or Preauthorization required? Yes No

Name of Employment if Group Insurance Coverage: _____

Secondary

Insurance _____

Address _____ City _____ State _____ Zip _____

Telephone: () _____ ID/Certificate/SS/Member Number: _____

Group # _____ Policyholder Name: _____

Relationship to Patient: Self Parent Spouse Other (*Please Indicate Relationship:* _____)

Policyholder's Date of Birth: _____ Co-Pay Amount: \$ _____ Deductible Amount: \$ _____

Insurance Effective Date(s): _____ Precertification or Preauthorization required? Yes No

Name of Employment if Group Insurance Coverage: _____

Insurance Authorization to Send Reimbursement Information and Assignment

I authorize Christian Psychological Center to furnish my insurance carriers information they may request concerning the treatment of my dependent(s) or myself. I assign to the Christian Psychological Center all payments for services rendered to my dependents or myself. I understand that I am financially responsible for any amount not covered by insurance.

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my copayment and/or deductibles are expected at the time services are rendered unless the therapist agrees otherwise. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) to which I subscribe and in which the therapist is a participating provider, I am personally responsible for the payment of 100% of the charges billed. I understand that, as a courtesy, CPC will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges.

I also understand that any court order I have is an agreement between the courts and me; this agreement is NOT with the therapist. I, therefore, am personally responsible for payment of all charges.

I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment. I realize that such action could require that the therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed.

In addition, if I have requested that CPC file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the therapist to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature _____

Date _____

Relationship to Patient: Self___ Parent___ Legal Guardian___ Other (Please indicate)_____

**CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE
OR A FEE WILL BE CHARGED.**

CHART NUMBER: _____

CLIENT'S NAME: _____

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CONTACTING YOU

Occasionally we might need to contact you for matters of a routine nature (such as changing an appointment time). Due to confidentiality, we would like your input as to where it is acceptable for us to contact you. If such contact is necessary, the receptionist will only leave his/her name and your doctor's name and our telephone number if you are not available when we call. No mention of Christian Psychological Center or the nature of the call will be given to the person who takes your message, unless we have your permission to do so.

Please complete the following, if applicable, to guide us in your wishes regarding contacting you:

-If we need to contact you, may we contact you by telephone at home? _____ Yes _____ No

-May we leave a message on your home answering machine? _____ Yes _____ No

-Home Telephone: () _____

-If we need to contact you, may we contact you by telephone at work? _____ Yes _____ No

-May we leave a message on your voice mail at work? _____ Yes _____ No

-Work Telephone: () _____ Ext. _____

-If we need to contact you, may we contact you on your cell phone? _____ Yes _____ No

-May we leave a message on your cell phone's voice mail? _____ Yes _____ No

-Cell Number: () _____

Periodically Christian Psychological Center sends information by mail regarding the Center, new services being offered, or request for completion of anonymous surveys in order to evaluate the quality of our services. Do you wish to have your name and address placed on this mailing list?

_____ **Yes**, I request my name and address be placed on this mailing list.

_____ **No**, I prefer not to participate.

Signature

Date