Registration Form

Section I **Patient Information** **Date** ______________

Name____ Nickname___________________________
Address: _________________________________ City ___________________ State ______ Zip___________
Phone: (_____) ________________ Work (_____) ___________________ Cell (_____) ___________________
The best time to contact me is: ________________ AM PM on my Home Work Cell
Date of Birth: __________________ Social Security Number/Green Card________________________________
Check Appropriate Box: Minor Single Married Widowed Separated Divorced
If Student, Name of School: _________________________City/State: ___________________ Zip: _________
Spouse or Parent's Name: ___________________________ Employer _________________ Phone: _________
Who may we thank for referring you? ___________________________ Relationship______________________
In case of emergency, please contact____________________________ Phone (____) _____________________
Email Address__________________________@_______________

Section II **Responsible Party**

Relationship to patient Self Spouse Parent Other
Name____ Phone (_____) ___________________________
Address____ City___________________ State______ Zip_______
Employer__________________________________ Phone (_____) ___________________

Section III **Release of Information**

**Please list anyone authorized to speak with the therapies regarding treatment, care or services provided*
Name____________________________ Relationship__________________________ Phone (_____) __________________
Name____________________________ Relationship__________________________ Phone (_____) __________________
Name____________________________ Relationship__________________________ Phone (_____) __________________

Section IV **Insurance Information**

Name of insured __________________________ DOB _______________ Relationship to patient _____________________
SSN ______________________ Name of employer ______________________ Phone (_____) _______________________
Address of employer _______________________________________ City ____________________ State _____ Zip ______
Insurance Company ______________________________ Enrollee ID ________________________ Group # ____________
Insurance Company Address _______________________________ City ____________________ State _____ Zip ________
Insurance Company Phone (_____) __________________________________

***********Do you have Secondary Insurance? If so complete the following information* ***********
Name of insured __________________________ DOB _______________ Relationship to patient _____________________
SSN _______________________ Name of employer _____________________ Phone (_____) _______________________
Address of employer _______________________________________ City ____________________ State _____ Zip ______
Insurance Company _____________________________ Enrollee ID ________________________ Group # _____________
Insurance Company Address _______________________________ City ____________________ State _____ Zip ________
Insurance Company Phone (_____) __________________________________

**I give my permission to Christian Counseling Center of Battle Creek to call and leave a message, if necessary, regarding appointments, scheduling or billing Yes No*

Signature of Patient or Responsible Party _____________________________________ ***Date*** _________________

Registration Form

Financial Policy

Welcome to what all of us hope will be a life changing experience for you and your loved ones. We have worked very hard to develop a program that will meet your individual needs. We all see our job as ministries that will help you begin the healing process in your life. The following information is provided to avoid any misunderstanding or disagreement concerning payment for our professional services.

CCCBC participates with a variety of insurance plans. We will submit claims on your behalf to the insurance company; however, as the client you will be responsible to any deductible, co-pay or co-insurance dictated by your insurance carrier. Keep in mind that even if your therapist is out of network with your insurance company we typically can still see you and provide therapy, we will also bill your insurance for you; however you may have a higher out-of-pocket expense. Co-payments and deductibles are due at the time of service unless prior arrangements have been made.

As a courtesy, CCCBC will obtain out-patient mental health benefits from your insurance carrier; we also request that the client call and obtain this information as well. ***The information we obtain is an estimate and not a guaranteed payment amount.***

It is your responsibility to ensure that any required authorization for treatment is provided to our office prior to your visit. If the required authorization is not obtained then client will be responsible for the cost of the visit.

If you have any questions regarding your insurance coverage, we will be happy to assist you. Specific coverage issues should be directed to your insurance company's member services department (the phone number is listed on the back of your insurance card.)

FAQ for your Insurance Provider:
Is my provider IN or OUT of network?
What is my deductible for IN and OUT of network and how much has been met this year?
Do I have a co-insurance or co-payment for out-patient mental health visits?
Is there a maximum number of visits allowed per calendar/plan year?
Does my plan require pre-authorization for services or testing?

Our practice believes that a good therapist-client relationship is based upon understanding and good communication Questions about financial arrangements should be directed to the office staff or your therapist. We will work together to develop a payment plan that is mutually agreed upon.

By signing below I understand it is my responsibility to obtain insurance benefits and any authorization that may be required from my insurance company.

Client/Representative Signature ____ **Date** _________
Client's Name (please print) ____ **Date** ___________

Registration Form

Client Agreement and Acknowledgements

Privacy Policy: I acknowledge having been offered CCCBC "Notice of Privacy Policies" and their "Clients Rights Statement." (______) please initial

Consent for treatment: I hereby consent to the treatment provided by CCCBC and the employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (_____) please initial

______________________________	____________________	___________
Client/Authorized Person Signature	**Relationship**	**Date**

Child and Adolescent Consent for Treatment

CHILD'S NAME ____ DOB ____________________

Certify that I am the *father* *mother* *legal guardian* of the above child/adolescent and that I do have legal custody of _________________________. I, hereby, give my authorization and consent for the above named childe/adolescent to receive out-patient assessment/therapy from CCCBC.

______________________________	____________________	___________
Client/Authorized Person Signature	***Relationship***	***Date***

Divorce/Legal Separation Collection Policy

It is the policy of CCCBC that the parent/guardian bringing a child/adolescent to out office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child/adolescent's treatment regardless of any financial arrangement for payment of medical care, either oral or written, with the child/adolescent's other parent or responsible party. CCCBC assumes NO responsibility for collecting payment from the other parent or responsible party with whom you maybe have financial arrangements for your child/adolescent's medical care.
I have read, understood and agree to the above policy:

______________________________	____________________	___________
Client/Authorized Person Signature	**Relationship**	**Date**
______________________________		___________
Witness Signature		**Date**

CHRISTIAN COUNSELING CENTER OF BATTLE CREEK

Registration Form

Patient Information and Consent to Treatment

Thank you for choosing CCCBC for your counseling needs. We are committed to giving you the best care possible. To familiarize you with the policies and procedures of our clinic, we are providing the following information.

Appointments: If you need to cancel an appointment, a minimum of 24-hour notices is required; otherwise you are subject to a $50 cancellation fee. In the evenings and on weekends you may leave a message with the automated attendant which will accurately record the date and time you placed the call. Our providers will to their best to be punctual for your appointment. We ask that you be punctual as well. If you are late, for any reason, you will receive the remainder of your scheduled time. This is necessary to provide excellent care to all of our patients.

Emergencies: In case of an AFTER-HOUR emergency, go to the nearest emergency room. To leave a message for your CCCBC provider, call his/her regular daytime phone number.

Financial Responsibility: Complete financial policy attached. You are fully responsible for all services rendered. We accept Visa, MasterCard, Discover and American Express as well as cash, money orders and personal checks for your convenience. There will be a $25 fee for payments returned as non-sufficient funds or non-payable. All services rendered will be billed to you or your contracted insurance plan through Associated Medical Professionals. If you have any questions regarding your account balance you may call (269) 815-5389 to speak with our billing service.

Confidentiality: Your patient records are the property of CCCBC and shall be treated as confidential. To insure quality record maintenance and patient confidentiality, CCCBC will conduct routine patient record audits. To comply with state and federal laws regarding patient confidentiality your records will not be released without the properly executed written consent. Everything about your care will be held in the strictest confidence (with the exception of situations which we are required by law to report; such as suspected or reported child abuse, etc.) If you choose to have your CCCBC provider(s) keep a third party informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file.

Please sign below to indicate you have read and understand the above notifications and that you are consenting to receive treatment by a CCCBC provider.

______________________________	____________________	__________
Client/Authorized Person Signature	***Relationship***	***Date***

1. What brings you to seek counseling at this time?

2. What do you want to gain from your counseling?