

# Merrimack Valley Counseling Association

Northcrest Executive Office Park • 39 Simon Street, Unit #2A • Nashua, NH 03060 • (603)888-4347 • Fax (603)577-9157

## Client Information Sheet

\*\*\* Please print this form, complete it and bring it with you to your first scheduled appointment. To protect the confidentiality of your health information, please do not e-mail this. \*\*\*

### Client Information

Name:	_____	_____	_____
	Last	First	M.I.
Address:	_____	_____	_____
	Number	Street Name	Apt/Unit Number
	_____	_____	_____
	City	State	Zip Code
D.O.B.:	____/____/____	Age: _____	Sex: _____
	MM DD YY		
S.S. #:	____-____-____		
Phone Numbers:	(____) _____	(____) _____	
	Home Number	Work/Cell/Alternative Number	
Marital Status:	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widower/Widow <input type="checkbox"/>
Employer:	_____	_____	
	Name	Address	
Occupation:	_____	_____	
	Title/Position	Length of Service/Years at Position	
Education:	<input type="checkbox"/> High School	<input type="checkbox"/> GED/High School Equivalency	
	<input type="checkbox"/> Trade School	<input type="checkbox"/> College: _____	
		Level	

### Spouse / Significant Other Information

Name:	_____	_____	_____
	Last Name	First Name	Relationship to Client
Address:	_____	_____	_____
	Number	Street Name	Apt/Unit Number
	_____	_____	_____
	City	State	Zip Code
D.O.B.:	____/____/____	Age: _____	Sex: _____
	MM DD YY		M/F
S.S. #:	____-____-____		

### Primary Insurance Information

Subscriber Name: _____	S.S.#: _____
Last Name                      First Name	
Subscriber DOB: _____ / _____ / _____	
MM                      DD                      YY	
Ins. Company Name: _____	Phone #: _____
	(usually on the back of your insurance card)
Subscriber ID# _____	Group #: _____
Ins. Rep Name: _____	Date Called: _____
Is the Plan:    HMO <input type="checkbox"/> PPO <input type="checkbox"/> Personal Plan <input type="checkbox"/>	Effective Date of Coverage: _____

### Secondary Insurance Information

Subscriber Name: _____	S.S.#: _____
Last Name                      First Name	
Subscriber DOB: _____ / _____ / _____	
MM                      DD                      YY	
Ins. Company Name: _____	Phone #: _____
	(usually on the back of your insurance card)
Subscriber ID# _____	Group #: _____
Ins. Rep Name: _____	Date Called: _____
Is the Plan:    HMO <input type="checkbox"/> PPO <input type="checkbox"/> Personal Plan <input type="checkbox"/>	Effective Date of Coverage: _____

### Emergency Information

Emergency Contact: _____	_____	_____
Last Name                      First Name                      Relationship to Client		
Address: _____	_____	_____
Number                      Street Name                      Apt/Unit Number		
_____	_____	_____
City                      State                      Zip Code		
Phone Number: (____) _____	(____) _____	
Home Number                      Work/Cell/Alternative Number		
Primary Physician: _____	_____	_____
Last Name                      First Name                      Hospital Affiliation/Practice Name		
Address: _____	_____	_____
Number                      Street Name                      Suite/Unit Number		
_____	_____	_____
City                      State                      Zip Code		

## **Statement of Confidentiality**

Within certain limitations, information by you and (if applicable) your child(ren) during the course of treatment will be kept strictly confidential and will not be revealed to any other person and/or agency without your written consent. At your request, any or all parts of your records can be released to any person and/or agency you designate (either verbally or in writing). There are certain situations in which Psychologists, mental health professionals and/or medical professionals are required by law to reveal information without your permission. These include:

- 1) When information is obtained suggesting clear suspicion that physical abuse, sexual abuse, or physical neglect has occurred to a minor;
- 2) When grave bodily harm or death is threatened to another person;
- 3) When serious suicidal intentions are conveyed and a client or their guardian refuses voluntary treatment to ensure the client's safety;
- 4) When a court of law issues a subpoena for information obtained during treatment in response to the order of a court of law; and
- 5) Reporting as mandated by HIPAA, The Health Insurance Portability and Accountability Act.

If you have any questions and/or concerns regarding your rights to confidentiality, please discuss them with your psychologist at the time of your appointment.

## **Confidentiality Agreement with On-Call Providers**

If any clinician/physician/ARNP is not available to review my records for consultation in an emergency situation, I consent to authorize the on-call clinician at Merrimack Valley Counseling Association to review my records.

## **Session Payment Policy**

The term "one therapy hour" is defined by most HMO, PPO and managed care companies as a 45-50 minute session (not a full hour or 60 minutes). To continue with our standard philosophy and concern for all clients, we will provide additional time for each client above the standard 45-50 minutes should the therapist's schedule allow this flexibility.

A 45-50 minute session is charged at our standard rate from \$125.00 to \$250.00 based on the level of expertise of the provider (examples: Master's Doctorate, ARNP, or MD). A 25 minute session (i.e. a half-hour appointment) is charged at a rate of \$62.50, etc. Fees are collected prior to the beginning of each session. For your convenience, we accept cash, check, Visa, Mastercard, or American Express.

We are currently mental health providers for several insurance carriers. Please ensure that you have your insurance card with you when you arrive for your session so that we may make a copy of it for your file. Please notify us immediately of any changes in your insurance coverage.

## **Cancellation Policy / Fee and Billing Policy**

Should you need to cancel or change future appointments, 24 hour notice is requested. Because appointments with psychologists are in great demand, and because your appointment time is reserved only for you and cannot be filled without sufficient notice, missed appointments or those canceled less than 24 hours in advance will be billed directly to you for the full session amount. Exceptions are made in cases where only extraordinary circumstances prevent adequate cancellation notification. Insurance will not cover any portion of the fees for a missed or canceled appointment.

**Insurance Provider Release of Records Consent**

In certain circumstances, we may need to release limited information to your insurance provider in order to obtain payment for your scheduled sessions. In order for us to release the necessary information, we must obtain your signed consent to do so. Please read the statement below and sign on the signature line as indicated.

*I authorize Merrimack Valley Counseling Association to release information to my insurance company as is necessary to obtain payment for services provided.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**Assignment of Payment / Promise to Pay**

*I have read the cancellation policy listed above and understand that except in extraordinary circumstances, missed appointments and those canceled without 24 hours notice will be billed directly to me at the full session rate. I also understand that insurance does not cover fees for missed appointments.*

*I also authorize my mental health provider or the health care vendor providing services or benefits to release any mental health substance abuse assessments or medical treatment information necessary to effect treatment or claim payments to Merrimack Valley Counseling Association.*

*I authorize payment of benefits to the Merrimack Valley Counseling Association for services rendered, providing other arrangements have not been previously negotiated. I also understand that I am responsible for any services and/or fees that are not covered by my insurance company.*

**Note: If client is a minor, parent and/or guardian will sign**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**X** My signature on this form attests to the fact that I do not and/or my spouse does not have (if applicable) any other insurance coverage in addition to my primary carrier.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date