KEYSTONE
FAMILY COUNSELING

CLIENT'S INFORMATION				
Today's date:		Primary Care Physician:		
Parent/Guardian's name (if applicable):		Relationship to Client:		
Client's name:		Birth date:	Age:	Gender: ❑ M ❑ F
Social Security No.:	Primary phone : ( )	Secondary phone: ( )	Marital status (circle one) Single / Mar / Div / Sep / Widow	
Street address:		City, State:	Zip:	
Occupation:	Employer:			
Chose practice because/Referred to practice by (please check one box): ❑ Dr. ❑ Family ❑ Friend ❑ Hospital ❑ Insurance ❑ Location ❑ Other_____				

IN CASE OF EMERGENCY		
Name:	Relationship to client:	Phone: ( )

INSURANCE INFORMATION (Please provide a copy of your insurance card)

Primary Insurance:

Policy Holder:	Birth date:	Client's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other	Social Security No.:
Policy No.:		Group No.:	
Insurance Address:		Insurance Phone: ( )	Co-payment: $
Occupation:	Employer:	Employer address:	Employer phone : ( )

Secondary insurance (if applicable):

Policy Holder:	Birth date:	Client's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other	Social Security No.:
Policy No.:		Group No.:	
Insurance Address:		Insurance Phone: ( )	Co-payment: $

The above information is true to the best of my knowledge If my insurance information provided is not correct I understand that if I do not provide correct insurance information within 60 days my claims may not be filed with my insurance and I may be financially responsible for any balance. I understand and agree that it is my responsibility as the client/guardian to notify Keystone Family Counseling, PLLC of any legal restrictions and/or requirements concerning the treatment of a minor i.e. as recorded in a divorce decree and that the appropriate consents and notifications as required will be obtained.

Client/Guardian Signature	**Date**

Client Name (cont.):	Birth Date:

MEDICAL RELEASE / CONSENT FOR TREATMENT

With this form I acknowledge I have been provided a copy of the NOTICE OF PRIVACY from KEYSTONE FAMILY COUNSELING and authorize the release and disclose of portions of my medical record necessary to obtain reimbursement for myself and for my covered dependents. This authorization gives KEYSTONE FAMILY COUNSELING the right to request and receive information from other health care entities and providers to include but not limited to copies of lab results, diagnostic test reports, and other clinic information deemed necessary by KEYSTONE FAMILY COUNSELING or representatives. I understand I am required to sign this authorization as a condition of my treatment, unless permitted by law. I also understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with KEYSTONE FAMILY COUNSELING privacy policy. I understand and give consent for my sessions to be documented with audio recording to ensure quality of care, and to ensure the protection of myself and the provider with the understanding of HIPPA compliance.

X_____

Client/Guardian Signature Date

ASSIGNMENT OF BENEFITS / CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby consent to any professional services which the provider(s) may consider or advise in treatment of my case (or as legal guardian for client). I hereby authorize any benefits due me to be paid directly to KEYSTONE FAMILY COUNSELING, 1172 E. 100 N. Suite 8, Payson, UT 84651. This agreement will remain in effect until I choose to revoke it in writing.

I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier.
A finance charge may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collection agencies, or failure to make necessary co-payments at the time of service. It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account. I assume full responsibility for payment of this account. It is understood and agreed that failure to appear for a scheduled appointment may result in the assessment of a "No Show" charge and I hereby agree to pay this charge. In consideration for services rendered, I acknowledge that I have received notice of the KEYSTONE FAMILY COUNSELING financial policy and agree to pay for said services according to such terms.
If the patient is, or will be, a qualified Medicaid recipient, I agree to assume payment responsibility for those services which exceed program benefits or are unauthorized by Medicaid. I agree to pay for such services at the rates posted on KEYSTONE FAMILY COUNSELING current rate schedule.

X_____

Client/Guardian Signature Date

LIABILITY/OFFICE FEES AGREEMENT

I acknowledge that I am responsible and liable for my own actions and the actions of anyone I bring to KEYSTONE FAMILY COUNSELING. This includes behavior in the waiting room, therapy room, or anywhere else on the property of KEYSTONE FAMILY COUNSELING or its provider(s). I also acknowledge that I am responsible for any appointment cancellations and that I may be charged a fee for missed appointments or appointments cancelled less than 24 hours in advance.

X_____

Client/Guardian Signature Date