FAMILY & CHILD DEVELOPMENT

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Phone: (850) 862-3772
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CLIENT INFORMATION

Fill out information for the person who will be the primary client. If this is your child, please fill out their information.

Name: _____
First Last

Date of Birth: _____ **SSN**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Marital Status (Please circle one): **Married** **Divorced** **Single** **Widow** **Child**

Cellphone: _____ **Home/Work/Other**: _____

Email: _____

If you would like appointment reminders and office correspondence, would you prefer:

_____ SMS/Text messages (Your cell provider may charge for this service; you may opt out at any time.)

_____ Cell phone voice message

_____ Email message

_____ Home phone voice message

_____ Please do not leave messages

INSURANCE INFORMATION

If Tricare is your primary insurance, the Identification number we need is the Benefits ID Number on the back of your Military ID.

Primary Insurance Information Company Name:_____

Name of Insured Policy Holder: _____

Identification Number: _____ **Group Number**: _____

Secondary Insurance Information (if applicable)**Company Name:**_____

Name of Policy Holder: _____

Identification Number: _____ **Group Number**: _____

EAP Authorization Number: _____

Authorization Begin Date: _____ **Authorization Expiration Date**: _____

Number of Sessions Authorized: _____

General Information Regarding Insurance:

Medical insurance coverage is a contract between you and your insurance company. Neither FCD nor your therapist is a party to your contract, and has no standing in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

If you have medical insurance, we are happy to file initial claims on your behalf to your insurance company for the services that are provided by our office. It is important that you understand that this in no way guarantees that your insurance company will pay for service rendered. All claims are subject to the written conditions of your policy. You, as the client, are ultimately responsible for the account and any follow up contact with your insurance provider. In addition, please understand that we are typically required to provide a diagnosis to your insurance company in order to be paid. Your signature is required in order to file insurance and receive services.

To help us process your claim correctly, please make sure that the information you provide to our office on the patient information form remains accurate and current. If there is a change in your insurance information, it is your responsibility to let us know immediately. We will submit secondary insurance if you indicate that you want us to perform this service on your behalf.

*****A SPECIAL NOTE** Situations such as separation or divorce can affect your insurance coverage, and it is your responsibility to let your therapist know about this kind of development.***

Deductibles, Co-Payments, and Coinsurance:

Co-payments are due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy, and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service.

Good Faith Estimate

All non-insured or self-paying clients will be provided with a good faith estimate of expected charges. Therapists will discuss fees before providing services and will notify the client both orally and in writing of the expected fee.

Authorizations:

A copy of your insurance card is required at the time of the initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company, and we must contact them to verify the necessity of an authorization. If a copy of the card is not on the file at the initial service and the claim is denied for "no authorization," you will be responsible for the payment

Whether you are using insurance or are self-pay, please understand that you are ultimately responsible for any payments or outstanding bills. Accounts that are past due will be turned over to our collection agency and may be reported to credit bureaus. We are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

Cancellation/Missed Appointment Agreement

Family and Child Development has a 24-hour cancellation policy. In the event that you do not call to cancel your appointment within 24 hours of your scheduled appointment, and you fail to show up for your appointment, you will be charged accordingly by your therapist. For example, your therapist may charge a penalty fee for a late cancellation or broken session, or you may be billed for the entire session.

Other Services Provided by FCD

Please be aware that most insurance companies will not cover services such as court appearances, report preparation, record copying, etc. If you anticipate needing this type of service, discuss it with your therapist, and please be aware that you may incur unreimbursed expenses.

I acknowledge that I have read and agree to the above terms and policies of Family & Child Development. My signature indicates that I have given this practice the right to file, on my behalf, for insurance payments.

_____ _____

Client or Responsible Party's Signature Date

Agreement to Treat

As the client, I hereby give permission for therapy, assessment, or diagnostic evaluation as seen helpful by the therapist to treat me, members of my family, my marriage, or other relationships. I understand that therapy may sometimes lead to unanticipated emotional stresses, as well as emotional improvement and that neither the therapist nor FCD guarantees any particular result or outcome from the therapeutic process. Furthermore, I understand that I am free to discontinue therapy at any time. I also understand that I have the right to question anything that occurs during therapy, and I am entitled to receive an adequate explanation of techniques or modes of therapy in use.

Understanding of Confidentiality

I understand that all records and information gathered during therapy will be kept in strict confidence by my therapist, as well as FCD staff and anyone affiliated with FCD. Therapists and anyone affiliated with FCD may not release any information regarding my therapy to others (including the fact that I or other family members are in treatment) except when specifically required by law or with my specific written consent.

Exceptions to Confidentiality

While clinical records are confidential, it is important for clients to recognize that there are times when a therapist or FCD staff may be legally or ethically obligated to divulge information from a client's record. In the case of child abuse/neglect, therapists and FCD staff are required by law to report any evidence or suspicion - with or without the client's consent. In addition, therapists and FCD staff are required by law and professional ethics to report a client's intent to either harm themselves or others. Finally, it is important for clients to understand that therapists and FCD staff are legally obliged to break confidentiality when ordered to testify by a court of law.

Recordings

Your therapist does not consent to being recorded in any form. This includes videoing, recording, screen-recording, and wiretapping. Recordings may be allowed if and only if your therapist consents and is actively aware that they are being recorded. Permission for a recording must be requested at any additional time you wish to record. Having permission in one instance does not substitute permission for any other future instance.

HIPPA Compliance

Family and Child Development has a policy that meets government standards for HIPPA (Health Insurance Portability and Accountability Act) which covers privacy of all medical information. If you desire to read or have a copy of our privacy policy please request this.

My signature indicates that I have read and understand the above terms and conditions of therapy, and have signed below to indicate my agreement with each of these terms and conditions.

_____ _____

Client or Responsible Party's Signature Date

Family & Child Development
Credit Card Pre-Authorization Form

I authorize Family and Child Development to keep my signature on file and charge my credit card as follows:

_____ I understand that my credit card number will remain on file for the duration of my treatment. Should there be a change in the card to be charged, it will be my responsibility to provide a new number immediately. My card will be charged the reserved day of service, and/or should I no-show for my scheduled appointment time.

_____ As noted upon intake, a 24+hour notice is required in order to avoid being charged. The charge will be either for the co-payment amount or a late penalty fee. Any no-show may be charged the full rate which the insurance company will not cover. The only exception that would be given would be in the event of an emergency, of which there would be no charge.

Please initial above, complete card information below and sign. Thank you.
Credit Card Type:
_____ Visa _____ MasterCard _____ Discover _____ American Express

Card Number: _____

Exp. Date: _____ Security Code_____

Cardholder Name: _____

Billing Zip Code: _____

X_____ Date: _____
Signature of Client or Guardian, if under the age of 18

FOR OFFICE USE ONLY: _____
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