Ebenezer Counseling Services

Adult Intake Form

Date: ________________ Email Address:______________________________

Name: ____

Address: ____

City: __________________________________ State: ___________ Zip: _________

Cell #: _________________________ Ok to leave a message? ______

Date of Birth: ___________________ Age: _______________

Sex: __________________ Marital Status: _________________

Presently Living with: Parents__ Spouse__ Roommate__ Alone__ Other__

Spouse's Name, if married: _____________________Years Married: ____________

If divorced, how long? ___________ Length of Previous Marriage(s): ____________

Occupation: _________________ Hours per week____

Employed by ____

May we contact you at work? __________ If yes, work #_______________________

If a student, what school/university? ___________________ Full or Part-time: _____

Who will be responsible for payment of bill? _________________________________

Relationship to patient? ________________

Address if different: ____

Will you be using insurance? _______ (If yes, please present your card to our staff.)

Education: Elementary School____High School____College____Other___________

Denomination or Church____

Active________ Inactive_______

Describe any physical problems you have that require medication or physical care:

____

Medication currently using: ____

Are you currently receiving medical treatment? Yes: ________ No: ________

Physician or health care provider: ____

Previous Therapy / Hospitalization: Yes: ________ No: ________

Where / with whom: ____
Name Address Dates

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place **two checks** by those items which are most important. *You may add written comments in the additional space below.*

1. _____ Anger / temper
2. _____ Depression
3. _____ Fearfulness / nightmares
4. _____ Unhappy most of the time / sadness
5. _____ Worry (constant)
6. _____ Family problems (siblings / parents)
7. _____ Family transitions (divorce, remarriage, birth)
8. _____ Responsibilities / chores
9. _____ Physical problems
10. _____ Religious / spiritual concerns
11. _____ Thoughts of suicide / hurting others
12. _____ Trouble making decisions
13. _____ Use of alcohol
14. _____ Use of drugs / cigarettes
15. _____ School concerns (grades, peer interaction)
16. _____ Problems with social relationships (friends)
17. _____ Sexual concerns
18. _____ Victim of uninvited sexual advances
19. _____ Other (specify) _______________

Additional comments regarding checked areas:

Is there any history of adoption in your family?

____

____

In your own words, briefly describe the main problem which prompted you to seek therapy at this time.

____

____

Is there anything else which you believe might be important for your therapist to know at this time?

____

____

CLIENT AGREEMENT WITH POLICIES AND PROCEDURES
WELCOME TO EBENEZER COUNSELING SERVICES

The following information is provided to assist you in understanding policies and procedures at ECS. We strive to provide you care of the highest quality. Please do not hesitate to ask questions of your therapist or our administrative staff at any time about these matters.

Therapists:

All Ebenezer therapists are trained professionally at the Master's or Doctoral level. Therapists are trained as psychologists, professional counselors, marriage & family therapists, or social workers. All ECS therapists work from a Christian perspective. A list of therapists and their professional identities are posted in the waiting rooms of our offices. Some therapists are working toward their licensure and are indicated on the posted lists as "Counselor in Supervision." We often also have interns who are counselors in training working toward a Master's or Doctoral Degree and are under supervision at ECS.

Appointments:

Since clients are seen by appointment only *(unless an emergency situation dictates otherwise),* the appointment time given is reserved for you. Please give at least **twenty-four (24) hours notice** if you must cancel your reserved time. Therapists depend on their appointments being filled for their income. If an appointment is missed, the therapist does not get paid. Therefore, **you will be charged your usual fee for appointments not canceled twenty-four hours in advance**. Please understand that insurance companies, churches, and employee assistance programs as third party payers cannot be charged for late cancelations or missed appointments, and you are fully responsible for any resulting charges. In the event of your having an illnesses or emergency that prevents you from giving us notice, call us as soon as you can; and you will not be charged for that missed session. ECS has time-stamped voicemail so you can leave cancellations after hours and on weekends.

Emergencies and Telephone Calls:

Should you need to talk to your therapist between appointments, you may leave him or her a voicemail or, if you have a portal, you can message your therapist there. Therapists vary in how frequently they check voicemail or portal messages. If your call is an emergency during normal office hours, you should declare your call to be an emergency, and your call will be returned by our therapist-on-call or other available therapist. After hours, you will hear our message with our pager number to reach the therapist-on-call.

Fees and Payments:

Payment is required at time of service. Fees were set when you made your first appointment. You were given a "No Surprise Billing" statement clarifying your fee. Appointments generally run 45-60 minutes. Most therapists work on a 50 minute session basis. We will file third party insurance forms for you, if you desire, but payment of the fee is still required at the time of service. If your insurance company pays benefits, you will be refunded for that amount.

Special fee structure for certain specified tasks such as psychological testing, consulting, or court-ordered appearances will be discussed with you and agreed upon before any charges are applied to your account. If your fees are not paid in a timely manner, ECS will contact you about payment. If payment is not made, ECS retains the right to use collection agencies. Clients are responsible for all fees owed to ECS and for any collection agency fees.

Insurance Usage and Issues of Confidential and Privileged Communications:

Many clients elect to file third party insurance coverage for services rendered. We will file insurance for you provided you authorize us to do so and provide us with the necessary information for filing such claims. Some insurance plans require an initial precertification of care before you can use your insurance benefits. It is your responsibility to make sure such pre-certification requirements are met if you elect to use your insurance benefits

(i.e., referral from your primary care medical doctor, employee assistance program, other "gatekeeping" mechanisms such as calling an 800 number for approval).

In filing the insurance claim for you, you are granting us permission to reveal confidential information, such as the dates you are seen, the length of the appointment, billing information, forms completed today, mental status information, your diagnosis, treatment plans, progress notes, reports or clinical summaries, and summaries of assessments. This type of information is required by your carrier if you want insurance to pay toward your claim. Additionally, many companies now require further utilization review and participation with outcome and quality measures. Unless your care is very brief, it is possible we will be forced to submit a more extensive report documenting the clinical and medical necessity for your care, as well as, revealing some of the details of your care to date if further sessions are going to be authorized by your carrier. Some carriers will require auditing/review of your records and outcome/quality care studies.

If you identify a third party such as a parent, relative, pastor, friend, church, or any other third party to be responsible for part or the whole of your bill, then by signing this policy statement, you are giving your authorization for the bill to be released to that party. By doing so, you realize that the third party will know about the frequency and number of sessions, cancellations, no-shows, balances, payments, insurance payments, etc.

Confidentiality:

Psychologists/therapists have a strong privileged communication law in our state which carries the same legal status as that of attorney-client. What you talk about in your sessions is protected by privileged communication laws and confidentiality principles. There are a number of important exceptions to confidentiality including but not limited to: expressing clear and imminent danger to self and/or others, suspected child abuse, worker's compensation related cases, utilization review reports for authorization of care, and compliance with chart audits by your insurance carrier. Additionally, therapists at ECS reserve the right to seek peer consultation and supervision within our agency regarding your diagnosis and treatment in order to better serve you. Apart from these exceptions, you must sign a written release of information for us to communicate with or release records to other persons or entities. We strive to maintain the sacredness and privacy of your confidential communications with us.

Other Issues of Policy:

In the event that a client of Ebenezer Counseling Services becomes verbally or physically threatening to office staff, therapists, or other clients, we reserve the right to call for help from the police or other emergency services as needed. We also reserve the right to file a police report and to pursue charges as appropriate to the situation. In the event of a client having a medical emergency, we reserve the right to call appropriate emergency services.

When a parent or parents come to ECS to discuss issues related to their child or children, the consultation sessions cannot be filed for insurance reimbursement under the child's name until the child is actually seen and diagnosed in a face to face session. If the child is not seen, no diagnosis can be given, and the parents are fully responsible for payment of the consultation sessions. The laws and rules pertaining to therapy with children are complex. Please see our website for guidance or feel free to communicate with our staff about this.

Your Informed Consent to Care:

We have provided this information to you in the hope of fully informing you about the policies of our office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychological care offers no absolute guarantee of success, and there are limitations to any form of care offered a client.

Please feel free to discuss any of these matters with your therapist in more detail. By signing below, you acknowledge that you have read, understood, and agree to these policies and procedures. Your signature acknowledges your informed consent for care.

____ ________________________

Signature of adult client or parent/legal guardian of client less than 18 years of age

Date

PAYMENT AGREEMENT

Ebenezer Counseling Services

I accept full responsibility for payment of charges for services rendered to the above named client. I understand that full payment is expected at the time services are rendered whether sessions are In-person, Telephone, or TeleHealth.

No Shows and Late Cancellations

I understand and agree that I am responsible for payment of session fees when the named client fails to show (no show) or appointments are not cancelled at least 24 hours in advance (late cancellation).

Supporting Churches or Businesses or Benefactors

In cases where therapy is supported financially by a church, business, or other benefactor, I understand that I am ultimately responsible for the Session Fees in the event the supporting agency or benefactor does not pay. Additionally, I am responsible for any amount of the Session Fee not covered by the agency or benefactor. The No Show and Late Cancellation policy also applies even when supported by and agency or benefactor. To be clear, I understand and agree to pay for No Shows or Late Cancelations and do not expect the church, business, or benefactor to pay this for me.

Insurance

If the client's therapist is licensed and able to file insurance claims with my insurance carrier, and if the therapist and I, the undersigned, agree to do so, and if there is an appropriate diagnosis in order to file a claim, Ebenezer will file insurance claims for the services provided excluding group therapy or testing. This does not release me of my responsibility for payment of the charges for services. I agree to pay session charges in full until the actual amount of insurance reimbursement is established. Ebenezer will refund or apply credit to my account for payments from insurance companies for which I have already paid. Payment of any charges denied or not covered by the insurance company are my responsibility, and I agree to pay these charges.

In addition, if I have requested that the therapist 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 client 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.

Court

I also understand that any court order is an agreement between the court and me or between the court and the client. It is not an agreement between the court and the therapist. Therefore, I am still responsible for payment of all charges.

Collection Agency

I further understand and agree that a collection agency will be used in the event of delinquent payment, and the added cost of the collection agency is the responsibility or the client or me. And 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, other information the collection agency needs to proceed with collection.

More than One Responsible Party

If I have agreed to share the responsibility of payment with another party (e.g., divorced parents), then I agree to be fully responsible for my agreed on portion of all charges. All of the above policies apply to my payment of my portion. Additionally, if I am responsible for a No Show or Late Cancellation, I agree to be responsible for the entire session fee. The other responsible party(ies) would not be responsible for this No Show or Late Cancellation.

______________________________	______________
Signature of adult patient or parent/legal guardian of patient less than 18 years of age	Date

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules").

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. Our Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Ebenezer Counseling Services

I,____, understand and have been provided a copy of Ebenezer Counseling Services' Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

____ __________________________

Patient Signature or Parent if Minor or Legal Charge Date

Date

If Legal Charge, describe representative authority: __________________________________

Informed Consent for Internet Assisted Counseling
Ebenezer Counseling Services v8.2

I the undersigned, declare that I understand the inherent risks and privacy concerns present in counseling via the Internet (ZOOM, Skype, Facetime, DOXY-ME, remoteEMDR for EMDR sessions, etc.) EMDR is a specialized therapy for trauma issues. Despite the concerns, I believe that using the internet to be the most effective method providing distance counseling (TeleHealth) and authorize Ebenezer Counseling Services (ECS) to provide counseling or remote EMDR sessions via the Internet. I understand that my TeleHealth counseling sessions are not recorded by ECS nor by myself and that my TeleHealth sessions are not stored in any way.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to troubleshoot or will call you back to complete the session. Please list your main number and an alternate number here: __________________ __________________.

In the event of an emergency during a TeleHealth session, I understand that I can call 911, or I could go to my nearest emergency room, or I could call the ECS Therapist on call at 865-850-7818. I agree that my therapist may send medical/psychological/law-enforcement help in the event of a life-threatening emergency during TeleHealth. Additionally: my emergency contact to call is __________________, phone ___________________.

If I send electronic messages through my portal to my therapist during the course of therapy, I do not expect my therapist to review or respond to my messages in any defined time period. I understand that I can discuss my message(s) at my next counseling appointment.

By agreeing to Internet counseling with ECS, I understand that ECS will keep all information confidential to the degree that ECS has ability; however, I acknowledge that I am responsible for the security of my home computer or electronic device to ensure that electronic information remains confidential. I also affirm that I will ensure that I am the only person present in the vicinity of my computer or electronic device during my counseling sessions. I acknowledge that Internet communications whether email or other TeleHealth methods are not secure, and I am willing to take the risk in order to proceed with the counseling process.

__________________________________ __________________
1st Signature Date

____
Printed Name

__________________________________ __________________
2nd Signature Date

____
Printed Name

EBENEZER COUNSELING SERVICES

325 EBENEZER ROAD
KNOXVILLE, TN 37923

(865) 670-0988
EBENEZERCOUNSELING.COM

131 N. CONCORD STREET
KNOXVILLE, TN 37919

Card on File Billing Policy

Our staff will be asking you to allow Ebenezer to keep a credit or debit card on file for us to charge when you come for your appointment or when you complete a TeleHealth appointment. This a great help to us, and we believe this will make your experience with Ebenezer be smooth and easy.

Many of you already have a card on file with us, and this has facilitated your payment process. We believe that this new policy of having your permission to charge your card automatically for our services will be helpful to you and to us. This in theory would negate the need for us sending statements for missed charges which would be a help to you and to us.

You will have access to the details of your **account on your portal**, and if there were to be a charge you question, you can send us a message or call, and we will be happy to clarify or correct it.

No Shows and Late Cancellations (less than 24 hour notice) would be charged on your card according to our cancellation policy which you agreed to when you became a client at Ebenezer (see our full cancellation policy on our website: EbenezerCounseling.com). So, please try to cancel early if needed or if you are sick or have another extenuating circumstance, please call to cancel (even if late) to avoid a No Show charge.

If you do not have a credit / debit card or if you are strongly opposed to this policy, then you can pay in advance by check, cash, or card (if you have one). However, if the account is not paid at the time of service, your therapist will have to wait before providing service. We would much prefer to avoid this by simply being able to charge your card on file.

If we are filing **insurance claims** for you, we will automatically charge the full session fee to your card-on-file until you have met your deductible. Once your insurance company starts to pay, we will only charge the card for your portion of the fee.

If you are supported by a **church, business, or agency**, we will bill them monthly and will charge your card for your portion only at the time of service.

If there is **more than one responsible party on the account**, e.g., two parents paying a percentage on their child's account, then each responsible party will give us a card to have on file. We will split the charge according to the agreed on percentages.

Thank you for reading this, and for your understanding. We think this will help decrease the stress of billing for everyone. The therapists especially will be so thankful.

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Card on File Policy Agreement

Choosing this option helps us and you in making billing easy.
(No accidently missed payments and no need for monthly statements.)

I, ____(print), certify that I have read the Card on File Policy for Ebenezer Counseling Services (Ebenezer). I give my permission for the staff at Ebenezer to charge my card for services for myself or dependents whether provided in person at Ebenezer or by TeleHealth or for No Show or Late Cancellation Charges.

I understand that I can request a review of any charge that I find to be in error and that the management staff at Ebenezer will work to clarify or correct the charge.

I understand that if insurance claims are filed for me or my dependent, then my card will be charged for my full session fee until my deductible is met. Afterwards, my card will only be charged for what the insurance company does not pay.

I agree to the Card on File Policy for Ebenezer Counseling Services.

______________________________________ ________________________
Signature Date

Card on File Policy Rejection

This option often results in missed payments, confusing billing, and monthly statements.

I, ______________________________________(print), understand that if I choose not to allow my card to be charged at the time of service or for no shows or late cancellations, that **I will pay for sessions in advance**. I agree to pay for No Shows or Late Cancellations in accordance with Ebenezer's 24 hour notice policy. I understand that if my session if not paid for in advance, the session could be delayed until payment is made.

______________________________________ ________________________
Signature Date

Do not sign this if you have agreed to the policy above.