A logo for a therapy center

Description automatically generated **Please type or print within space or select response**

**1733 Wooddale Blvd ▲ Baton Rouge, LA 70806 ▲ 225-924-2800 Phone / Fax ▲** [**info@eclecticcbc.com**](mailto:info@eclecticcbc.com) **▲** [**www.eclecticcbc.com**](http://www.eclecticcbc.com)

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| **New Client** **Retuning Client** | **client information form** | **Client ID#:** |

**Name:  DOB: Age:  Sex: \_\_\_\_\_\_\_\_\_\_ SS#: **

**Address:** ** City:  State:  Zip: **

**Prim Ph#:  Sec Ph#:  Email:  Prefer contact: \_\_\_\_\_\_\_\_\_\_ Leave message: \_\_\_\_\_\_\_**

**Marital Status: \_\_\_\_\_\_\_\_\_\_ Living with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minor’s Parent/Guardian:  Minor's Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation:  Employer:  Employer Ph#: **

**Emergency/Support Contact Name:  Ph #:  Client Relationship: **

**Service(s) Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **InOffice** **Telehealth** **Both Referral Sources:  Ph #: **

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| **insurance information** | **OFFIC USE ONLY** |
| **Responsible Party:**  **Subscriber:  DOB:**  **Address:**  **City/State/Zip:**  **Ph #:  Email:**  **Subscriber’s ID#:**  **Relationship To Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber’s Employer:**  **Policy/Group Name**: **Group/FECA#:**  **Authorization Required: Yes No Authorization #:**  **Deductible $: CoPay $: Specialty CoPay $:** | **Insurance Provider:**  **Ph #:  Email:**  **Fax#:  Website:**  **Claim Address**:  **City/State/Zip:**  **Claim Inquiry Ph#: Claim Processing:**  **Insurance Type:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **In Network:** Yes No **Electronic Filing**: Yes No  **Effective Date: Terminate Date:**  **Deductible $: CoPay $: Specialty CoPay $:**  **Limit $:  Amt Satisfied $** |
| **Health Information** | |

**Primary Physician:  Ph#:  Specialist:  Ph#: **

**List Medication: **

**Describe serious physical / medical health condition: **

**Describe Psychological / Educational Evaluation: **

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| **Current concerns / Problems** |

**Reason for counseling services? **

**When did the problem begin? How does the problems affect you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you received treatment before?** No Yes / When ** Is there a Family History of this problem?** No Yes / Who ****

**List your counseling / therapy goal(s):**

1. ****
2. ****
3. ****

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| **behavioral/emotional symptoms** | | |
| Loss of interest in work, school, daily activities  Loss of interest in sex / maintaining arousal  Loss of interest in hobbies/social activities  Loss / change in appetite  Trouble sleeping / Insomnia  Unintentional weight gain or loss  Feeling sad, helpless, or trapped  Feeling guilt  Worry, panic or fear  Restlessness, irritability, nervousness  Loss of energy, fatigued, or weak | Hyperactive, Impulsive, out of control  Unexplained aches, pains, or muscle tension  Hallucinations / hearing voice, seeing things  Delusions / Incorrect inference  Detached, disconnected or weird  Angry/Hostile  Mood swings  Thoughts of harming self or others  Preoccupation with death or dying  Crying spells for no apparent reason  Trouble concentrating or mind going blank | Bizarre or Repetitive thoughts/behavior  Difficulty making decisions  Suspicious/distrust of others  Hyperventilation, or trouble breathing  Heart palpitations or chest pain  Headaches, dizziness, or faintness  Hot flashes, sweating, or chills  Stomach upset, cramps, or nausea  Frequent urination or diarrhea  Alcohol or Substance Use/Addiction  Smoking or Nicotine Use / Addiction |

**Client/Parent/Guardian’s Signature:  Date:  04/2024**

Logo, company name

Description automatically generated **Consent/****Authorization****for Treatment Policy**

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| **adult Client**  **(18 and Older)** |
| I understand that:   * my involvement and cooperation are required and is key to effective treatment; that regular attendance and completion of therapeutic assignments are essential; and that failure to do so may result in termination of services. * all identifiable, diagnosis and treatment information are confidential and will not be released to any agency or individual without my written consent, except when required by law, and conducting standard health care operations. * the provision of treatment requires communication of Protected Health Information (PHI) among Eclectic’s administrative staff, and my insurance/third-party payer; and that PHI is collected and stored on an electronic database, and that at all times my privacy and care will be treated with the highest regard. * Eclectic may consult with other health care providers in order to provide the best treatment possible for me; and that my written consent may not be required when PHI is not released for such purposes. However, should it be necessary to consult with my Primary Care Physician/Specialist about my specific diagnosis and treatment, my written consent is required. * all consent/authorizationsshall remain in effect until further notice and may be modified or revoked at any time; and that revocation of consent may result in a loss of insurance benefits and services. |

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| **MinoR Client**  **Parent/Guardian authorization or consent to treatment children under the age of 19 is required!** | |
| Additionally, I understand that:   * parental/guardian participation is required in the treatment of a minor; and that *Family Counseling/Consultation* is necessary in the treatment of a minor; which may result in additional fees. * my child's regular attendance and completion of therapeutic assignments are essential; and failure to do so may result in termination of services. I understand that my failure to participate in *Family Counseling/Consultation* may result in termination of services. * treatment planning may require consultation with others involved with my child’s care in order to provide the best treatment possible. Should it be necessary to consult with my child’s Primary Care Physician/Specialist or Teacher, my written consent is required. * children less than 15 years of age shall be accompanied by an adult entrusted by me (parent/guardian), unless otherwise stated herein. * guardianship, custody, and/or domiciliary orders established by a Court of Law may be required for a child who does not reside with both parents. | |
| **Mother’s Name**  **Address**:  **City/State/Zip:**  **Ph #:  Email:** | **Father’s Name**  **Address**:  **City/State/Zip:**  **Ph #:  Email:** |
| **Minor child lives with**   Father  Mother  Both/Shared  **Are both parents aware of child’s treatment?** Yes  No | |

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| My signature on the *Policy Acknowledgment & Informed Consent* *F****orm*** affirms my receipt of the ***Consent to Treatment Policy***.  Moreover, Iunderstand, and agree to the conditions set forth therein.  This consent/authorizationshall remain in effect until further notice; and it may be modified or revoked at any time.  Revocation of consent may result in a loss of insurance benefits and services. |

**(review otherside for Minors**) **(Revised: 04/2024)**

Logo, company name

Description automatically generatedPolicy Acknowledgment & Informed Consent F**orm**

My signature below affirms my receipt of, understanding, agreement and consent to the conditions set forth by Eclectic’s in the following policies:

* *Professional Declaration*
* *Financial Policy*
* *Confidentiality / Privileged Communication / Medical Record Policy*
* *Consent/Authorization to Treatment Policy*
* *Consent to Mental Health Services & Format*
* *Consent To Treatment Associate / Provisional Licensed Professional Counselor*
* *Consent to Contact / Communication*
* *Consent to Release PHI To Insurance / Third Party Payer Policy*
* *Medical Physician/Specialist Consent to Release PHI*

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| **Consent to Mental Health Services & Format** |

**Consent to Services Format:** I understand that Eclectic offers three (3) formats of Mental health services, ***Onsite/In-Office Format*** (clinician’s office or an appropriate physical location), ***Telehealth/Teletherapy Format*** (counseling/psychotherapy services using interactive HIPAA secure technology-assisted media via synchronous video/audio conferencing transmission), and a ***Hybrid Format*** (a combination of Onsite/In-Office and Telehealth/Teletherapy Format). I understand that both Onsite/In-Office Format and Telehealth/Teletherapy Format are delivered in accordance with regulatory and ethical standards consistent with HIPAA and Hi-Tech standards of practice. I understand that clients who cannot be diagnosed or treated properly via telehealth/teletherapy services shall be dismissed and treated onsite/in-office, and/or properly terminated with appropriate referrals.

*I hereby consent to receiving mental health services via the following format:*  In-Office  Telehealth  Hybrid (In-Office & Telehealth)

Clients in remote areas are advised to identify a Support Person who can physically contact the client within minutes to assist in an emergency.

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| **Consent to Treatment by PLPC/Counselor Interns** |

I understand that *Eclectic* is a training center for Licensed Professional Counselor Associates and (LPCA) Licensed Professional Counselor (PLPC), and Graduate Counselor Interns. I understand that I may have the option to be seen by LPCA/PLPC**/**Counselor Intern. I understand that the LPCA/PLPC**/**Counselor Intern are supervised by a licensed mental health clinician, and that Protected Health Information (PHI) may be discussed with their respective supervisor regarding my treatment. Moreover, I understand that my objection to be seen by an LPCA/PLPC**/**Counselor Intern shall in no way jeopardize services with Eclectic.  Yes, I consent  No, I DO NOT consent to receiving mental health services from PLPC**/**Counselor Intern.

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| **Consent to Contact/Communication format** |

I understand that telecommunication mediums (phones, text messaging, emails, postal mail, etc.) are not a secure way of preserving confidentiality of patient’s PHI, nor a reliable method of contacting clients or ***Eclectic*** in crisis/non-crisis situations.

I consent to receiving communications as noted on the C*lient Information Form* HmPh CellPh Email Text Other: 

**with message via:** Voicemail Person Answering Email Text.

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| **Consent to Release Protected Health Information to Insurance / Third Party Payer** |

I understand that patient consent is required to r***elease information to insurance or a third-party payer*** for verification of coverage, benefits, and claims.

Yes, I consent to release PHI to Insurance/Third Party Payer  No, I DO NOT I consent to release PHI to Insurance/Third Party Payer .

**Insurance/Third Party Payer: **

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| **Signature Authorization** |

My signature below affirms my receipt of the forementioned policies; and my understanding, agreement and consent to the conditions set forth by Eclectic’s ***Policies*** as referenced herein.

This consent/authorizationshall remain in effect until further notice. I understand that my consent to all or any policy or condition may be modified and/or revoked at any time; and that revocation of consent may result in a loss of insurance benefits and services.

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| **Client's Name: Client/Guardian's Name:  Minor's Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client/Parent/Guardian's Signature:  Date:** |

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| **FOR OFFICE USE ONLY**  **Approved by**:  **Date:**  **Released by:**  **Date:** |

I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Eclectic Cognitive Behavioral Center.

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| **Revocation of consent TO TREAT** |
| **Client's Name: Client/Guardian's Name:  Minor's Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client/Parent/Guardian's Signature:  Date:** |

**(Revised: 05/2024)**



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| ***Renewing The Mind* ▲ *Transforming Lives*** |
| **1733 Wooddale Blvd ▲ Baton Rouge, LA 70806 ▲ 225-924-2800Phone ▲ 225-924-9280 Fax ▲ info@eclecticcbc.com ▲ www.eclecticcbc.com** |

Consent to release **Protected Health Information (PHI**)

I understand that the review of educational and/or medical records may be necessary in diagnosis and treatment of behavioral/mental health conditions. I therefore consent to the release and/or exchange of ***Protected Health Information* (PHI)**.

**Release :**  **To** **From: ** **Phone#:  Fax: **

**Address: ** **City:  State:  Zip: **

I authorize Eclectic Cognitive Behavioral Center, to Disclose/Receive (X) information contained in my record to/from:

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| **Information RELEASE**  Biopsychosocial History  Diagnosis & Assessment Report / Results  Treatment Notes / Plans  Discharge Summary  Referral  Other: | **Information Requested**  Complete Medical Records  Diagnosis & Assessment Report / Results  Treatment Notes / Plans  Discharge Summary  Referral  Other: |

**Disclosure Method:** Copy of Medical Record Verbal Consultation Written Forms/Report

I understand that my record may contain information) related to academic grades/status, substance abuse/dependence, behavioral/mental health, physical health (including medications, sexual abuse/assault and/or disciplinary infractions. This information will be disclosed unless I specify that the information is not disclosed by initialing the following:

Substance Abuse/Dependency  Sexual Abuse/Assault  Mental Health  Physical Health, specify 

The treatment dates covered by this authorization are from  **to** 

**DISCLOSURE**

This information has been disclosed to you from records protected by State and Federal Laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. Information related to alcohol/drugs, mental health, sexual assault, and specific health conditions are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.

A copy of the Authorization shall be deemed valid as original. This Authorization must be signed and dated.

I understand this release is valid  days or 12 months from the date it was signed; and that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

I understand authorizing the use and/or disclosure of this information is voluntary and that I need not sign this form to ensure healthcare treatment and that information may be shared among Covered Entities for the purpose of care coordination without my consent.

I acknowledge that Eclectic Cognitive Behavioral Center and/or its staff are not legally liable for the interpretation or use of information by person(s) to whom information is released.

My signature below affirms my understanding, and consent to the release of records/information to the person(s) noted herein as stated above.

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| **Client's Name: Client/Guardian's Name:  Minor's Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client/Parent/Guardian's Signature:  Date:** |

|  |
| --- |
| **FOR OFFICE USE ONLY**  **Approved by**:  **Date:**  **Released by:**  **Date:** |

I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Eclectic Cognitive Behavioral Center.

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| **Revocation of consent TO TREAT** |
| **Client's Name: Client/Guardian's Name:  Minor's Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client/Parent/Guardian's Signature:  Date:** |

**(Revised: 05/2024)**

Logo, company name

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**Eclectic Cognitive Behavioral Center, LLC**

**1733 Wooddale Blvd⏶Baton Rouge, LA 70806⏶225-924-2800 Phone/Fax⏶info@eclecticcbc.com /**[**www.eclecticcbc.com**](http://www.eclecticcbc.com)

**Credit Card Authorization**

Patients utilizing Health Insurance, Employee Assistance Program, or other forms of Third-Party Payers, are required to secure their appointment / services with a *Credit Card Authorization* for incidental charges not covered by Insurance/*EAP/Third-Party Payers such as* *Co-Pays, No Show ($75 per session),* *Late Cancelation (less than 24-hour notice prior to scheduled appointment), Outstanding Balances, Denied/Rejected Claims*, etc.

**PAYMENT IS DUE AT THE TIME OF SERVICES**

While we accept various forms of Health Insurance, Employee Assistance Program, or other forms of Third-Party Payers, payment for services is the responsibility of the client/patient. We attempt to submit claims to *Eligible Insurance Carriers* (insurance company that Eclectic is affiliated/credentialed with) on behalf of client/patient. However, insurance payment/reimbursement is not guaranteed, and is the responsibility of the client/patient.

Notification of charges to credit card will be emailed to the client/patient following processing.

Clients may request a ***Payment Plan*** for charges that exceed $500.00, with balances payable in 3 monthly installments.

***Credit Card Authorization***

**Name: **

**Address: **

**City State Zip**

**Telephone:  Email: **

**Assessment/Evaluation: **

**Cost: $ Deposit: $ Balance: $ Amount Received: $**

**Card #:  Exp Date:  CV Code:  Zip Code: **

**Name on Card:  Authorize Signature**  **electronic**  **real **

**Credit Card Processing Fee $5.00 pre transaction**

**Invoice/Receipt will be emailed following transaction**

*Credit Card Authorization* expires one year from the date of *authorization***.**