



5500 W Pinnacle Point Drive, Suite 203/204 Rogers, Arkansas 72758
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CLIENT CONSENT FORM / PRIVACY NOTICE

The Department of Health and Human Services has established a “Privacy Rule” (HIPAA) to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient’s/client’s consent for uses and disclosures of health information about the client to carry out treatment, payment, or health care operations.

As our client, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. Exceptions to privacy include our concern that you may seriously harm yourself or others, or abuse or neglect of children or elderly. Also, upon your completion of a Release of Information form, we will forward records with your consent.

We also want you to know that we support your full access to your personal medical records. We will also furnish the required Personal Health Information to your insurance company in order to acquire payment reimbursement for services to you.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions or objections to this form, please ask to speak with our HIPAA Compliance Officer.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____



FINANCIAL AGREEMENT

We will be glad to check your insurance benefits and file claims as a courtesy to you. It is your responsibility to provide us with accurate insurance coverage information, including any changes to the policy coverage.

By signing below you are assigning insurance payments to Pinnacle Counseling. Also, you agree to be ultimately responsible for the amount due for services rendered, in the event that insurance denies your claims for any reason.

All payments are due at the time of service. We will provide you with an estimate of your expected charges such as co-pay, or the amount due towards deductible. Your portion is due in full at each visit. We accept cash, credit cards and checks.

As a valued client, we will hold a scheduled appointment time for you. We reserve the right to charge for appointments not cancelled in advance. In the event that you need to cancel an appointment, please do so with at least 24 hours' notice, so that the spot may be released to others. Emergency situations will be considered.

Please be advised:

Medical Insurance **does not pay for marriage counseling.** However, most insurance policies do pay for counseling for anxiety and depression or adjustment disorders. By indicating your participation with insurance benefits, you are agreeing to the medical necessity and that you are being treated for concerns affecting your mental health.

This consent becomes effective on _____.

Client Signature _____ Date _____

Parent/Guardian _____ Date _____



NEW CLIENT INFORMATION

NAME _____ Preferred Name: _____

ADDRESS _____
STREET APT. CITY ST ZIP

SEX (M) ____ (F) ____ DOB ____/____/____ MARITAL STATUS _____

PRIMARY PHONE # (_____) _____ TEXT # (_____) _____

EMAIL: _____

EMPLOYER _____

SPOUSE, PARENT OR SIGNIFICANT OTHER? _____

WHO LIVES IN YOUR HOME? _____

HOW DID YOU LEARN ABOUT US? _____

EMERGENCY CONTACT: _____

Name

Phone #

COMMUNICATION:

Pinnacle Counseling uses a variety of methods to reach clients including voice, phone message, text, and email. Please be specific in writing if any method is unacceptable to you.

REVIEW OF OUR SERVICES:

We strive to provide the highest quality of services. We may periodically follow up in one of the above methods to get your feedback.

SOCIAL NETWORKS:

We feel it is important for counselors and clients to connect. As an agency, we are active on Facebook, Twitter, and Pinterest. We also publish a blog accessible via our website: www.pinnaclecounselingNWA.com. The blog contains useful information on mental health, family wellness, and personal change.

- www.facebook.com/PinnacleCounseling
- www.twitter.com/Pinnacle_Cares
- www.pinterest.com/PinnacleCares

Client Signature _____ Date _____

REASONS FOR SEEKING HELP:

Are you experiencing symptoms of:

Anxiety: _____

Trauma: _____

Depression: _____

Alcohol Abuse: _____

Stressful Adjustments: _____

Substance Abuse: _____

Other: _____

Family Physician: _____

Name of Clinic: _____

When did you last see your family physician? _____

What was the reason for that visit? _____

When did you last have a complete physical examination? _____

PLEASE CIRCLE YES OR NO BELOW

- | | | |
|-----|----|--|
| YES | NO | Fainting spells, Passing out, or Falling |
| YES | NO | Epilepsy, Convulsive Episodes, or Seizures |
| YES | NO | Bad headaches |
| YES | NO | Pains in your chest |
| YES | NO | High blood pressure |
| YES | NO | Stomach trouble or ulcers |
| YES | NO | Diabetes |
| YES | NO | Liver disease or skin or eyes turn yellow |

YES NO Any medical condition preventing you for working? If yes, explain, _____

YES NO Any other medical problems? If yes, please list, _____

YES NO Family history of mental illness or addictions? If yes, list illness and family member, _____

YES NO Have you been hospitalized in the last 3 years? If yes, where and for what problems? _____

HABITS:

Sleep _____ hours/night

Coffee _____ cups/day

Tea _____ cups/day

Soft Drinks _____ per/day

Water _____ glasses/day

TOBACCO:

Cigarettes _____ packs/day

Cigars _____ per/day

Other? _____

ALCOHOL INTAKE:

12 oz Beer _____ per/day

_____ per/week

6 oz Wine _____ per/day

_____ per/week

1 oz Liquor _____ per/day

_____ per/week

Have you used any of the following in the past 2 years?

Marijuana

YES NO

Last Use / Frequency: _____

Cocaine

YES NO

Last Use / Frequency: _____

Opiates (Oxycodone, Vicodin, Heroin)

YES NO

Last Use / Frequency: _____

Amphetamines (Meth, Adderall, Vyvanse)

YES NO

Last Use / Frequency: _____

Benzodiazepines (Klonopin, Clonazepam)

YES NO

Last Use / Frequency: _____

Others

YES NO

Last Use / Frequency: _____

(Synthetic Marijuana, Ecstasy, DMT, Inhalants)

What medications are you taking now? _____

What other medication have you been prescribed for a mental condition (depression, anxiety, etc.)?

