5500 W Pinnacle Point Drive, Suite 203/204 Rogers, Arkansas 72758
Phone: 479-268-4142 Fax: 888-732-7108

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 **Relationship** **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: www.facebook.com/PinnacleCounseling. 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.

Client Signature_______________________________________ Date___________________________

Pinnacle Counseling

feel better, live better

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 from 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?___________
____

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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 (Synthetic Marijuana, Ecstasy, DMT, Inhalants)	YES	NO	Last Use / Frequency: _________________

What medications are you taking now?____

____

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

____

____