1 Oglethorpe Professional Blvd. Suite 201
Savannah, Ga. 31406
Phone (912) 352-7638 Fax (912) 352-7492

E-Mail

barnabascenter1@gmail.com

WEB
www.barnabascenter.net

Thank you for your commitment to counseling through the Barnabas Center for Counseling. We appreciate the confidence you have shown in us. This information is provided to enable us to have a clear understanding of how we could best serve you. Our desire is to provide solid, Biblically-based treatment that is both Christ centered and affordable. Because we are a 501(c)3 non-profit corporation we rely on your timely bill payments to continue to serve our community.

Each session is 50 minutes in length and will be billed at the stated price (fees are subject to change). Increments will be added for each additional quarter hour. Payments and co-pays are due and payable before your session begins. Payments are expected at the time service is rendered. If more than 2 sessions have been kept and payment has not made we will not be able to schedule any additional appointments until payment has been made unless previous arrangements have been made with the office: We have several options available to you concerning payment of fees. We accept cash, check or credit cards (Visa, MasterCard, Discover & Am Ex).

Some insurance companies will reimburse for our services. It is your responsibility to contact your insurance company for coverage and requirement information. If you would like to pursue insurance, please inform the office as soon as possible. If we are on the provider list for your insurance company, we will file the appropriate claims and reimbursement will be sent to our office. Please be advised that if insurance does not cover the services we provide you will become fully financially responsible for any and all charges you incur. Also please note your co-pay, deductible or co- insurance is your responsibility and due at the time of your visit.

It is understood that if, because of non-payment, your account is turned over to a collection agency, you will be responsible for all collection fees.

I hope these guidelines are helpful to you. Previous experience has shown that it is helpful to have certain guidelines regarding payment of fees to help make this therapeutic process for you a smooth one. If you have any questions or any special circumstances, we would be happy to discuss them with you.

Keith Niager, LCSW William Immel, LPC Catherine Clevenger, LCSW
Executive Director

Erin Adams, LPC Anne McDaniel, LPC Suzanne Stangland, LPC

Emily McAleer, LPC

I have read and agree with the above guidelines.
Client or Guardian Signature: _____Date: _____
PLEASE NOTE: ALL ENCLOSED FORMS MUST BE FILLED OUT COMPLETELY AND RETURNED AT YOUR FIRST VISIT

APPOINTMENT POLICY

The Barnabas Center is committed to providing you with the highest quality of care. Great effort has been made by all of our therapists to see you in a timely manner. Quite often there is a waiting list of 2 or 3 weeks. We ask that you make every effort to keep your appointments and be on time. When we have no shows or last minute cancellations we do not have adequate notice to give that time to anyone else, especially those that have been on a waiting list.

Therefore, you **must** give a **24 hours' notice** (not just the day before, but **24 hrs.** notice) for any appointment you need to cancel. This allows us adequate opportunity to give that time to someone else. This is out of professional courtesy to us, and allows us to schedule someone that may be in great need to come in. We understand if an event occurs beyond your control.

****Therefore without proper notice you will be charged a late fee of $70 for each missed session. Insurance does not cover missed appointments****

As a courtesy to you, there is a system in place to call, text, & email to remind you of your appointment. We also want to respect your privacy and confidentiality. We will only remind you with your permission.

We appreciate your understanding in this matter. I have read and agree with the above guidelines.

Please Initial below:

_____ **Yes** I give the Barnabas Center permission to reminder me about my appointment.
You may call/text me at _____.

_____ **No** I do not need a reminder.

Regarding Children in Adult Sessions

We want you to be able to maximize your time in counseling, with no distractions.

Childcare coverage is not provided, therefore, we ask that you make supervision arrangements for your children while you are in counseling.

If your child is the patient and a minor, please have an adult accompany them for sign in and sign out processes (unless you make specific arrangements with the office).

We appreciate your understanding in this matter. Please initial that you have read and agree with the above guidelines.

Please Initial: _____

The Barnabas Center Mission Statement

The Barnabas Center for Counseling is a biblically based center. Our doors are opened to everyone regardless of age, sex, race, or religious affiliation.

Please Initial: _____

Confidentiality Policy

You should expect what you share with your therapist to remain private and confidential. If we are billing a third party we must provide certain information concerning a diagnosis, services rendered and your identity. We will be pleased to discuss this with you at your request. If we are asked to share information with others outside the agency, we will require written consent on a form signed by you.

- Your right to confidentiality and our ability to protect it are limited in the following three areas:

1. We are required by law to report suspicions of child abuse, serious neglect or sexual abuse.
2. We are required by law to report homicidal or suicidal intent.
3. We do not have immunity or privilege when subpoenaed by a Court; in those cases, we are required to testify or provide requested documents.

Acknowledgement

If there is anything in this material you do not understand or wish to clarify, please ask your therapist.

Otherwise, your signature indicates that you have read this document and understand it.

Patient/Guarantor Signature: _____ Date: _____

CLIENT INFORMATION - PLEASE PRINT and COMPLETE EACH SECTION

First Name_____ Middle_____ Last_____

Street Address_____ City_____ State_____ Zip Code _____

Home Phone_____ Business Phone_____ Alternate Phone_____

Social security #_____ Date of Birth_____ Email: _____

INSURANCE — PLEASE PRESENT YOUR INSURANCE CARD

Insurance Company_____ Address_____

Policy #_____ Group #_____ Insured's Name/ Sponsor_____ DOB: _____

Name of Insurance (additional)_____ Address_____

Policy #_____ Group #/ Effective Date_____ Sponsor's Name_____

Information provided to the office from your insurance company regarding your benefits of coverage is not a guarantee of payment. They have the right to deny any claims that are not covered by your policy. If services provided are not covered by your insurance policy, patient and/or liable party will become fully and financially responsible for all charges not covered. If insurance covers these sessions, patient and/or liable party is only responsible for his/her copay/deductible at the time of the visit.

FINANCIAL RESPONSIBILITY

First Name _____ Middle_____ Last _____

Street Address_____ City_____ State_____ Zip Code_____

Social Security # _____ Date of Birth _____

Home Phone_____ Business Phone _____ Employer's Name _____

I consent to treatment necessary for the care of the above name client.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.

I authorize Barnabas Center for Counseling to release information about me to the Health Care Financing Administration and any affiliated insurance companies regarding services which may be covered by Medicare. Medicare payments, if any, will be made directly to the Barnabas Center. Regulations pertaining to Medicare assignment of benefits apply. A copy of this authorization may be used in place of the original. I may revoke this consent at any time.

I authorize Barnabas Center for Counseling to release information about me which may be necessary to my private insurance company regarding services which may be covered by my policy. Insurance payments, if any, will be made directly to the Barnabas Center. A copy of this authorization may be used in the place of the original.

I may revoke this consent at any time.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date: _____ Signature: _____

Barnabas Center for Counseling
New Client Information

Date: _____ Name: _____

Referred by: _____

Accompanied by: _____ Relationship: _____

PRESENTING PROBLEM S/SYMPTONS, *PRECIPITATING EVENT/ DURATION:*

_____

_____

_____

Circumstances presenting a danger to self or others (including plans/means)			
	Yes	No	Describe
Past Suicide Attempts/Plan			
Current Suicide Plan			
Suicidal Ideation Current			
Suicidal Ideation Past			
Homicidal Ideation			
Self Harm Episodes			
Family History of Suicides			
Comments:			

Social Assessment

Employment: [ ] Employed [ ] Unemployed [ ] Retired [ ] Student Disabled (reason)_____

Employer/School: _____

Occupation: _____ Length of Employment_____ Shift: _____

School/Job Satisfaction: [ ] Yes [ ] No

Factors affecting Job/School: Performance [ ] Absenteeism [ ] Co-Worker problems [ ] Termination [ ] Other_____

Education: Highest grade / degree achieved: _____

Marital Status: Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ]

Length of present /last marriage: _____ Children (ages): _____

Description of Relationship with spouse or significant other: Supportive [ ] Non-Supportive [ ]

Spouse or significant other's occupation: _____ **N/A**

New Client Information

Drug Use/Abuse Related Problems:(Check all that apply)

DUI ___# of DUI's	____ Wrecks/ Traffic Violations
___Employment	____ Marital/ Family Relations
___Probation	____ Incarcerations

Social Support

___Church	____ Support Groups
___ Family Support	____ Other

Legal: Current legal Problems _____ Yes ____ No

If yes, please give details _____

_____

MEDICAL:

Current Medical Problems: _____

_____

HISTORY OF MEDICATIONS FOR THE LAST 6 MONTHS _____ N/A

Name of Drug	Dosage	Conditions for which taken	How long have you taken?

Any past treatment for psychiatric or substance abuse? Where/When? _____

_____

Family history of mental illness and/or substance abuse? _____

_____

NEW CLIENT INFORMATION

CHECK THOSE AREAS APPLICABLE:	*YES*	*NO*	*DATE*	*DESCRIBE*
1.HISTORY OF PRESENTING ILLNESS				
a. Problems functioning at work/home/school				
b. Deterioration in hygiene				
c. Loss of energy/interest				
d. Social withdraw				
e. Difficulty concentrating				
2. SITUATIONAL STRESSORS				
a. Financial concerns				
b. Marital family conflict				
c. History of physical/sexual abuse				
d. Significant losses				
e. Other				
3. EATING				
a. Change in eating habits?				
b. Loss___ Gain__ Amount_____ Over how long a period of time?				
4. MOOD DISTURBANCE				
a.Mood swings / how frequent?				
b. Crying Spells				
c. History of Depression				
d. Irritability				
e. Outbursts				
5. ANXIETY				
a. Nervousness				
b.Phobias				
c. Excessive Worry				
d. Panic				
e. Obsessive /compulsive behaviors				
6. STEEP DISTURBANCES				
a. Not sleeping				
b. Frequent Awakenings				
d. Nightmares				

Signature: _____ Date: _____

Fee Schedule

Initial Eval Visit (50 mins)	Self-Pay $105.00
Subsequent Visits (50 mins)	Self-Pay $85.00
Missed/Canceled w/o 24 hrs. notice (not just day before, 24 hrs. prior to the scheduled appt. time) or reasonable explanation	$70.00
Letters (cost varies depending on extent of letter)	$30.00 to $60.00
Court actions resulting in the Subpoena of a therapist.	$190.00/hr (plus travel time)

Please Initial below**

_____**Most insurance is accepted, however, it is the patient's/responsible party's duty to find out coverage of benefits for these services **before the appointment**. Insurance form is included and must be completed or patient/responsible party will be charged for sessions**

_____****Co-pays are expected at each visit before the session begins**. Patients are to check in at front desk upon entering the facility to make the necessary payment arrangements. UNPAID balances are subject to COLLECTIONS**

_____**Self pay rate is available for those who have no insurance and/or have a high deductible plan. If you choose to do self pay insurance will not be billed.**

Thank you,

The Staff of Barnabas Center for Counseling

PLEASE NOTE: ALL ENCLOSED FORMS MUST BE FILLED OUT COMPLETELY AND RETURNED AT YOUR FIRST VISIT.

AS A COURTESY WE FILE INSURANCE HOWEVER IT IS YOUR RESPONSIBILITY TO KNOW YOUR COVERAGE. INSURANCE WILL NOT BE FILED UNTIL THIS FORM IS COMPLETED & RETURNED. YOU WILL BE RESPONSIBLE FOR THE FULL FEE FOR ALL SESSION CHARGES INCURRED PRIOR TO ITS RETURN

The Barnabas Center for Counseling

Please call your insurance company and ask them the following questions. On your insurance card there may be several telephone numbers: You want to call the number or option that is for Mental Health/Substance Abuse or it may be under Behavioral Health.

Patients Name: _____ DOB: _____
Policy Holders Name: _____DOB: _____
Insured's ID: _____ Group ID: _____
Effective Date of Policy: _____ Insurance Telephone #: _____

Does your plan cover counseling by a Licensed Clinical Social Worker or a Licensed Professional Counselor in an outpatient office setting? : _____

Ask if the assigned provider,_____ for your appointment is in your network?_____

IF the answer to #2 above is NO, ask if your plan pays for out-of-network benefits. _____

Is there a deductible/amount? $_____ How much of the deductible has been met? $_____

Is there a co-pay or percentage you pay per visit if so, how much? _____

Does your plan cover therapy codes (CPT Codes 90791, 90837, 90847 & 90846)? _____

Is there a visit or $$ limitation on visits per calendar year/benefit period?
_____

Do visits need to be preauthorized and if a treatment plan is required? _____

If authorization is required and you are going to be coming in with family or if patient is going to be a minor, you need to let them know that you will need family and individual visits.

If it does need to be authorized ask them for the authorization number: _____

Effective dates: from_____ to _____ How many sessions? _____

Ask for the claim submittal address (this is not always the same as what's shown on your card)

_____
_____
_____

Name of Rep. who gave you information: _____Date you called: _____

Patient Signature: _____
Date: _____