FOR OFFICE USE ONLY
DX CODE(S): _____
ACCT #: BSCC_____

Better Solutions Counseling Center

New Client Information Sheet

Please complete ALL information.
*** Highlighted Portions MUST Be Filled Out for Insurance Purposes****

Client Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Referral Source: _____

Social Security Number: _____ Email Address: _____

Telephone Number: _____ Cell Phone Number: _____ Would you like text message appointment reminders? ☐ YES ☐ NO

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

Physical Address (If Different from Mailing): _____
STREET/P.O. BOX CITY STATE ZIP

Emergency Contact Name: _____ Relationship: _____

Telephone Number: _____ Cell Phone Number: _____

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

Insurance Company: _____ Policy #: _____ Group#: _____

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

Policy Holder's:

Name: _____ Date of Birth: _____ Social Security Number: _____

Medicaid Number: _____ State if not Wyoming: _____

Client/Guarantor Signature: _____ Date: _____

Client/Guardian Initial _____ ☐ Reviewed Consent to Treat and signed

Client/Guardian Initial _____ ☐ Reviewed Client Payment Agreement and signed

Client/Guardian Initial _____ ☐ Reviewed Client Confidentiality & Notice of Privacy and Understands

Client/Guardian Initial _____ ☐ Reviewed Client Rights (HIPAA)

Therapist Signature: _____ Date: _____

Better Solutions Counseling Center

General Consent to Treat

Client Name: _____ Today's Date: _____

I authorize and request Better Solutions Counseling Center, therapist(s) to carry out evaluations, treatment and/or diagnostic procedures that now, or during the course of treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request.

Further, I understand that, if at any time, my counselor is suddenly unable to continue to provide professional services or maintain records due to incapacitation or death, he/she has designated the BSCC Board of Directors, who are licensed mental health professionals, as his/her professional executor. If he/she dies or becomes incapacitated, the professional executor will be given access to all my client contact information and may contact me directly to inform me of my counselor's death or incapacity. He/She will assist me in making arrangements to provide for my continued care as needed. If I have any questions or concerns about this arrangement, I should contact my counselor.

_____ _____
Client Signature Date

If client is a minor:

_____ _____ _____
Parent/Guardian Signature Relationship to Client Date

_____ _____ _____
Parent/Guardian Signature Relationship to Client Date

_____ _____
Therapist/Witness Signature Date

Better Solutions Counseling Center

Payment Agreement and Assignment of Benefits

Highlighted Portion MUST be Completed if You do NOT have Insurance

Client Name: _____ Today's Date: _____

All services/counseling provided by Better Solutions Counseling Center (BSCC) are fee based and I understand that I am financially responsible for payment at the time services are provided. I also understand that it is my responsibility to schedule and keep all appointments made. In the event that it becomes necessary to cancel an appointment, I will do so as soon as possible.

Initial intake appointments are billed at a rate of $250.00 per hour and all sessions after are billed at $200.00 per hour. Other services will be provided based on the current fee schedule. Insurance co-pays or deductibles are payable at the time of service.

Any questions or concerns regarding fees and/or payments should be brought to the attention of the BSCC staff immediately. Should it become necessary to secure the services of a collection agency, the client/guarantor is responsible for all fees incurred.

_____ _____
Client Signature Date

If client is a minor:

_____ _____ _____
Parent/Guardian/Guarantor Signature Relationship to Client Date

_____ _____ _____
Parent/Guardian/Guarantor Signature Relationship to Client Date

Assignment of Benefits (if you do not have insurance or Medicaid, payment is due at time of service):

BSCC accepts Blue Cross/Blue Shield, UMR and Medicaid insurances, but **not** Medicare. It is the client's responsibility to inform BSCC of any changes in insurance coverage and the client is responsible to pay for any services received during a period of lapsed coverage.

The above-named client currently has health insurance benefits that are assigned to Better Solutions Counseling Center. This assignment allows BSCC to release the required information to request payment for services provided. Allowable payment(s) will then be made directly to BSCC. Any unpaid portion becomes the client's responsibility. The client/guarantor is responsible to pay any deductibles and/or copayments due at the time of service.

_____ _____
Authorized Signature Date

_____ ☐ **Initial here if "Not Assigned"**
Relationship to Client

_____ _____
Therapist/Witness Signature Date

Legal and Ethical Client Rights

Client Name: _____

I have had this form, *Legal and Ethical Client Rights,* reviewed by me. I received a physical copy for my records.

Signature: _____ Date: _____

Therapist: _____ Date: _____