* **McArthur Counseling Center** **2025**

New Client Information Sheet

Please Print Clearly

CLIENT: **Date**:_____

Legal Name:_____
First MI Last

Street Address: _____
Street Address CAN NOT be PO Box City State Zip

Mailing Address: _____
City State Zip

Birth date: _____**M / F** **SSN:** _____--_____--_____

(H) Phone: _____ **(C) Phone:** _____

E-Mail:_____

Employer: _____**Position:**_____

Family / Personal Physician :_____**Location:**_____
Pharmacy Name:_____**Location:** _____

Emergency Contact:_____**Phone#:**_____

Marital Status: Single Married Divorced Separated Widowed

PARENT: (if minor) or SPOUSE (if married)

Name:_____
First MI Last

Address: _____

Birth date: _____ **SSN:** _____--_____--_____

(H) Phone: _____ **(C) Phone:** _____

Employer: _____ **Position:** _____

For what reason(s) are you seeking counseling at this time? _____
_____
_____

Referred by:_____

* **McArthur Counseling Center Insurance Policies** **2025**

Full payment is due at time of service

We accept Cash, Checks, Visa, MasterCard and Discover

FINANCIAL POLICY

We DO NOT carry outstanding balances. All outstanding balances will be collected at time of service and or after your insurance carrier has processed your claim, in accordance to our contract. **Additional fees will be charged for all balances that are more than 90 days old**. A **$5.00 statement fee** will be charged to all accounts 90 days and older each month.
DELINGQUENT ACCOUNTS WILL BE SUBJECT TO COLLECTION/COURT ACTION OR TERMINATION/SUSPENTION OF SERVICE.

Parents bringing in a minor child; The parent that brings the child is responsible for any and all payments/charges regardless of any court order or decree.

INSURANCE POLICY

We may accept assignment of insurance benefits after your first visit. However, we do require any deductibles and / or co-pays to be paid at the time of service. **The balance is your responsibility whether your insurance carrier pays or not.** Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Check with your insurance for your exact benefits.
Our charges have been established based upon current (insurance approved) reasonable and customary rates for our area. Should your insurance company be unable to meet current standard payment scales, you will be responsible for the difference.
We will file your insurance as a courtesy to you. Filing with your insurance carrier **does not guarantee** benefits will be paid to us. The balance remains your responsibility.
If at any time, your insurance changes, you must notify us immediately.

*****McArthur Counseling Center does not file secondary insurance.*****

If you have Medicaid as your secondary insurance carrier by signing this form you are waiving your rights to any and all Medicaid benefits. We do not accept secondary insurance.

****Please complete the following REQUIRED information…Policy Holders:**

_____ _____
****Legal Name of Policy Holder** ****Date of birth**

_____ _____
Social Security Number ****Relationship to client**

_____/_____/_____/_____ _____
ADDRESS City St. Zip Phone

_____ _____ _____
Insurance Company Name Insured ID # ****Employer**

Thank your for understanding our Financial and Insurance policy. Please let us know if you have any questions.

_____ _____
Signature of Client or Responsible Party **Date**

Client Name_____ Date of Birth_____

CONSENT FOR TREATMENT

I voluntarily consent to receive mental health services including but not limited to examination, treatment, diagnosis, or prevention of a mental condition. Such services will be provided within the scope of the provider's license, certification and training or the scope of the license, certification, and training of those mental health providers directly supervising the services judged necessary by the professional staff of McArthur Counseling Center. I acknowledge that no guarantee has been made to me about the results of this treatment. I understand my right to know the purpose, risk, benefits and alternatives regarding any proposed treatment. Email communications become part of medical records.

AGREEMENT TO PAY

I agree to pay McArthur Counseling Center all charges for services rendered in connection with treatment of the above mentioned client. Payment is due at the time of service at the rates listed below, prices subject to change without notice:

***Initial BioPsychosocial Assessment: $150.00** ***Psychotherapy Sessions require 53 minutes: $125.00**

***Court Fees: $350.00 per hour out of office-includes travel time, $125.00 charged for each client canceled**

***Letters $50.00-must be paid prior to letter being written**

*** Drug Tests $25.00** *** $5.00 Statement fee for accounts over 90 days delinquent**

***Telehealth services are self pay only and follow all self pay charges.**

Telephone Calls and or Phone Sessions, Letters and Court charges are not Covered By Insurance

I agree to pay in full for appointments broken or missed without a 24-hour advance notice. I understand that insurance will not pay for these broken appointments, therefore, I am fully responsible for such charges. I also agree to pay for depositions, court appearances and contacts with attorneys. I will be personally responsible for these charges even if my insurance company does not pay. I agree to pay for charges related to record retrieval, copying costs and statements of opinion when I authorized release of my records to any outside party. In the event of default I promise to pay any such collection costs, 8% interest and any attorney fees related to the effort of collection of the indebtedness. Client agrees that Elkhart County shall have jurisdiction over any legal proceedings that may ensue as a result of client's failure to comply with the terms of this agreement.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize the direct payment of benefits under my medical insurance to McArthur Counseling Center or its designated professional staff. I understand that in order to obtain insurance reimbursement, the signature of a licensed MD may be required by my insurance company. I authorize McArthur Counseling Center to disclose whatever information they deem necessary in the process of determining a diagnosis and informing the consulting MD.

NON-VOLUNTARY DISCHARGE FROM TREATMENT:

A client may be terminated from MCC non-voluntarily, if: A) The client exhibits physical violence, verbal abuse, carries weapons or engages in illegal acts at the clinic and/or B) The client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

PRIVACY PRACTICES/OFFICE POLICIES:

I have been offered the ***Notice of Privacy Policies*** to review and have been given the ***Office Policies***._____

Initial please

I have read this agreement carefully before signing.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian (if minor) Date