NEW HOPE
COUNSELING CENTER
heal · restore · equip

35037 Royal Place * Soldotna, AK 99669 * (907) 260-7423

CLIENT INFORMATION FORM

Client Name: _____ Adult☐ Minor☐
First MI Last

Mailing Address: _____
Address City State Zip Code

Residential Address: _____
Address City State Zip Code

Parent or Guardian Name: _____ Relationship to minor:_____

Guardian address if different from minor: _____
Address City State Zip Code

Contact Email: _____ Phone Number_____

Emergency Contact (1) _____ Phone Number_____

Emergency Contact (2)_____ PhoneNumber_____

Informed Consent For Tele-Behavioral Health

I have received and understand the information provided regarding Tele-Behavioral Health (TBH), I have discussed the consent with my therapist or the Intake Coordinator, as may be designated, and all of the questions have been answered to my satisfaction. ***I hereby give my informed consent for the use of Tele-Behavioral Health in my care.*** New Hope Counseling Center conducts HIPAA secure TBH sessions either through the Valant Patient Portal or the VSee app:, a secure video conferencing site that works similarly to Zoom.**(Inil) _____**

GOOD FAITH AGREEMENT

The following is a detailed list of expected charges for therapy. These prices are subject to change according to the current Medicare rates. You will be notified of changes as they occur. Group fees are paid per module regardless of attendance. There is a cancellation fee of $30.00 if the therapy session is not canceled within 24 hours of the scheduled time.

- $236 each for two intake sessions
- $135/45-minute psychotherapy session
- $200/60-minute psychotherapy session
- We accept most insurance programs and participate with several Employee Assistance Programs.
- We offer a 25% administrative discount for clients paying out of pocket for counseling services.
- Payment must be received at the time of service to be eligible for this discount
- $30.00 fee for a cancellation less than 24hr
- If you are sick, cancel as soon as possible so we may refill that appointment
- **I acknowledge I have reviewed the current fees. (Init) _____**

Payment Authorization

To protect your privacy, please provide the name(s) of anyone who will be paying for the appointments. By initialing this section, you give permission for the following people to pay for the appointment/s. **(Init)_____**

Authorized payer (1) _____Relationship_____

Authorized payer (2) _____Relationship_____

MULTIPLE INSURANCE COVERAGE

For those with more than one insurance coverage, due to cost and time constraints, we are only able to bill your primary insurance. However, we will be happy to assist you by providing you information so that you may submit a claim to your secondary insurance company. Should secondary insurance companies submit checks to NHCC, we will reimburse clients once ALL secondary insurance funding has been received.

Please remember that insurance is a contract between you and your insurer. We are happy to help as much as we can to ensure payment of your benefits, however, we cannot, and will not become involved in disputes concerning deductibles, copayments, secondary insurance, or what insurance companies refer to as "usual and customary" reductions (init) _____

I understand that payment for all treatment received is my responsibility. I hereby authorize the release of any information to my insurance company that is required to process a claim on my behalf, including, but limited to, insurance appeal rights on my behalf. I also hereby authorize my insurance company to remit payment for any behavioral health benefits due directly to New Hope Counseling Center. These authorizations shall expire the first day of the new year, or upon my written notice. (Init) _____

****I acknowledge that I have received a copy of HIPPA Privacy Practices, Client Rights and Responsibilities and the Financial Policies (Init)_____ By signing this form, I give my permission for treatment of the above named person.

Printed Client Name _____ Printed Responsible Party Name_____