Clearwater Counseling

Welcome to Clearwater Counseling!

We are pleased you have chosen to come to Clearwater Counseling. Our staff look forward to working with you. Clearwater Counseling is dedicated to providing the best possible mental health services to the community. We strongly encourage you to take an active role in your counseling experience, and we're pleased to discuss any questions you may have.

Prior to your first appointment, it is important that you discuss our fees with your insurance company and inquire as to whether they accept your counselor's credentials. Ultimately, you are responsible for the fees for services rendered. Our office is open Monday –Friday. There is no childcare available. In the case of an after-hours emergency, please call 911.

Clearwater Counseling's goal is to assist clients in resolving their own problems. We believe that as you and your counselor work together to address your concerns, you will develop a sense of self-awareness that will influence your behavior and feelings. As a client, you are in complete control and may end our professional relationship at any point. We will be supportive of that decision. We also have the option of ending our counseling association if we determine it is in the best interest of both parties. If counseling is successful, you will feel better able to face life's challenges in the future without our support or intervention.

We will keep confidential anything you say to us, with the following exceptions: (1) you direct us to tell someone else; (2) we determine you are a danger to yourself or others; (3) there is suspicion of abuse of a child or vulnerable adult; and/or (4) we are ordered by a court to disclose information.

Complete information about Clearwater Counseling is included in the Professional Disclosure Statement you received. Clearwater Counseling assures you that our services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

If you have any questions, feel free to ask.

Thank you!

_____ _____

Client Signature Date

_____ _____

Counselor / Facilitator Signature Date

Client Name: _____

Mailing Address: _____

E-mail: _____ **Home Phone:** (_____) _____

Cell Phone: (_____) _____ **Work Phone:** (_____) _____

At which number may we leave confidential messages: ◯ Home ◯ Cell ◯ Work

Birth Date: _____/_____/_____ **SSN:** _____-_____-_____

Gender: ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Employer: _____ ◯ Full-time ◯ Part-time

Have you obtained services from Clearwater Counseling before? ◯ Yes ◯ No

Are you seeing another Mental Health counselor? ◯ Yes ◯ No

INSURANCE INFORMATION

Primary Insurance Company: _____

Claims Address: _____

Phone Number: (_____) _____

ID Number: _____ Group Number: _____

Insured's Name: _____Relation to client: _____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Employer_____

Secondary Insurance: ◯ Yes ◯ No If yes, which is primary? _____

Company: _____

Claims Address: _____

Phone Number: (_____) _____

ID Number: _____ Group Number: _____

Insured's Name: _____ Relation to client: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Employer_____

Do you have Medicare or Medicaid? ◯ Yes ◯ No

RESPONSIBLE PARTY FOR BILLING AND PAYMENT:

◯Check if same as client; **OR**

Guarantor Name: _____

Mailing Address: _____

Relationship to Client: _____

Home Phone: (_____) _____ **Other Phone:** (_____) _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____

_____ _____ _____

Guarantor Credit Card Number **Exp.** **CCV**

FINANCIAL POLICY

I understand all payments for treatment received are my responsibility. I authorize the release of any information to my insurance company required to process a claim on my behalf. I authorize my insurance company to remit payment for any medical benefits due directly to Clearwater Counseling. I authorize the release of relevant information to my insurance carrier or other provider as required to establish benefits, and I agree to assign those benefits to Clearwater Counseling. This authorization is valid unless I revoke it in writing. It may be revoked or renewed as desired by both parties.

A clear understanding of the financial responsibility for your care is important. Please read this form carefully.

Our Fees: Our fees are derived using a system called the Regional Based Relative Value System, a commonly accepted standard method of setting fees. It uses information based on federal insurance programs and a conversion factor.

Payment: We accept cash, check, or credit card. Please provide a credit card to keep on file for payment.

_____ _____ _____

Credit Card Number **Exp.** **CCV**

Insurance: Remember that you are ultimately responsible for your bill.

- If you have private insurance, **as a courtesy**, we will bill your carrier for our services once per visit.
- All **new patients are asked to pay the full amount of your first visit at the time of the visit**. We will refund you any overpayment.
- **All patients are asked to pay the full amount of the visit at the time of the visit at the beginning of the year until your deductible is met**. You will then be asked to continue to pay "your percentage" at the time of subsequent visits.
- **Any overpayment will be refunded** to you.
- **If your insurance pays and there is still an outstanding balance, you will be billed**; and the amount owing will be due upon receipt of your first statement from our office
- **If your insurer has not paid for any reason, you will be billed and are responsible** for the balance upon receipt of your first statement from our office.
- **If you have secondary insurance, we will bill your secondary insurance once** when we receive payment from your primary insurance company.
- **Insurance is a contract between you and your insure**r. We will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or "usual and customary" reductions.

Professional Disclosure Statement

Clearwater Counseling
122 10th Ave., Fairbanks, AK 99701
(907) 457-6002; (907) 457-3610 fax

Provider: Dave Bates, LPC

Fee Schedule:

Initial session	(60 minutes)	$380.00	
Individual and Family sessions	(30-50 minutes)	$185.00	
Individual and Family sessions	(50-90 minutes)	$260.00	
No-shows and late cancellations		$75.00*	(***initial***____)

*Subject to change without notice

Reduced Fee:

Financial assistance is available on a limited basis to those who qualify.

No-show and Late Cancellations Policy:

In the event that I am unable to keep an appointment, I must notify the counseling office at least 24 hours in advance. If I do not call to cancel or reschedule my counseling appointment, I will be charged for the missed session.

Privacy Practices:

I have been given the opportunity to read and understand Clearwater Counseling's Client Notice of Privacy Practices.

This information is required by the Board of Professional Counselors which regulates all licensed professional counselors.

Board of Professional Counselors
Division of Occupational Licensing
PO Box 110806, Juneau, AK 99811-0806

I have been given the opportunity to read and understand Clearwater Counseling's Professional Disclosure Statement and Clearwater Counseling's No-Show and Late Cancellations Policy (above). At any point I may request to receive a copy of these Statements, Policies and/or Practices.

_____ _____

Signature of Client/Representative Relationship Date

_____ _____

Signature of Guarantor (if different from Client) Date

COUNSELING / MEDICAL HISTORY

Have you previously sought counseling? Yes No

If yes, please explain:

_____

_____

Medical history:

_____

_____

Current Health Status: Excellent Good Fair

How long has it been since your last physical exam? _____

Current medications: _____

Chemical Use

History: Yes No

Current: Yes No

Substances: _____

Frequency: _____

Amount: _____

Length of use: _____ Longest period of sobriety: _____

Prior Treatment:

_____

_____

_____

Counseling/Medical History Continued

Rate the items with which you are currently having problems below.

Circle the number that best indicates the existence or severity of the problem:

0=None 1=Minor 2=Moderate 3=Significant 4=Serious

Circle the word(s) in brackets that best define(s) each statement:

Name: _____

Anxiety [Worry] [Fear] [Panic] [Phobia]	0 1 2 3 4
Feelings of [Depression] [Sadness]	0 1 2 3 4
Thoughts of [Death] [Suicide]	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Mood Swings	0 1 2 3 4
Grief over [Death of Loved One] [Major Loss]	0 1 2 3 4
Issues Related to [Pregnancy] [Abortion]	0 1 2 3 4
Abuse [Physical] [Domestic] [Emotional] [Ritual]	0 1 2 3 4
Sexual Abuse [Incest] [Rape]	0 1 2 3 4
Parent(s) had [Alcohol] [Drug] Problem(s)	0 1 2 3 4
Marriage Problems	0 1 2 3 4
Relationship Problems with Children	0 1 2 3 4
Problems with [Parents] [Family]	0 1 2 3 4
Sexual [Concerns] [Problems]	0 1 2 3 4
Problem [Alcohol] [Drugs] [Smoking] [Other]	0 1 2 3 4
Feelings of [Hopelessness] [Helplessness] [Despair] [Guilt] [Worthless]	0 1 2 3 4
Memory [Forgetfulness] [Changes]	0 1 2 3 4
Diminished interest or pleasure in all, almost all activities	0 1 2 3 4
Fatigue or loss of energy nearly every day	0 1 2 3 4

Have you ever felt people were watching you?	Yes	No
Do you hear voices?	Yes	No
Do faces ever seem distorted?	Yes	No
Do colors ever seem too bright or dull?	Yes	No
Have you attempted suicide?	Yes	No

In your own words, state the concerns that bring you to counseling:

_____

_____

_____

_____

_____