Callahan Counseling Services

PO BOX 1074
1020 Winchester Ave
Martinsburg, WV 25402-1074
P - 304-886-4118
F - 304-579-8606

130 Augustine Ave
Charles Town, WV 25414
P - 304-451-0989
F – 304-596-8003
CallahanPLLC@aol.com

Today's Date: **PCP:**

CLIENT INFORMATION

Client's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Sgl ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Maiden Name	Birth Date	Age	Gender ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security #	Home Phone No. Ok to leave Msg. Y N ( )

P.O. Box	City	State	ZIP Code	Cell Phone No Ok to leave Msg. Y N ( )

Occupation	Employer	Employer Phone No. ( )

Email: Employer Fax #: ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ☐ Dr. _____ ☐ Insurance Plan ☐ Attorney

☐ Family ☐ Friend ☐ Close to Home/Work ☐ Advertisement ☐ Other _____

☐ Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No. ( )
SS#			

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐

☐ Other

Subscriber's Name	Subscriber's Social Security #	Birth Date	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Peter J. Callahan, PLLC, d.b.a Callahan Counseling Services.. I understand that I am financially responsible for any balance. I also authorize Callahan Counseling Services or my insurance company to release any information required to process my claims. I also understand that Callahan Counseling Services may use a third party billing form, NueMD, to process my insurance claims.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

X _____
WITNESS SIGNATURE DATE

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1020 Winchester Ave, Martinsburg, WV. 25402-1074 ~ **(304) 886-4118**
130 Augustine Ave, Suite 128, Charles Town, WV 25414 ~ (304) 451-0989

FINANCIAL AGREEMENT

I agree to pay on the following basis: (Check One)

_____Private Insurance Co-Pay $_____ ID# _____

_____ Self-Pay _____ OTHER _____

Fees:

I understand that the fees for services are due at the time of service, unless otherwise agreed upon in advance.

I understand that I will be billed for any fees incurred for laboratory work over and above the customary screenings required in this treatment program. Also, optional consultations with outside physicians, counselors, and/or specialists, and any necessary prescriptions are my financial responsibility. **I understand that a fee of $65.00 will be charged for NO SHOW appointments or appointments cancelled with 24 hours of scheduled time.** I understand I may not schedule another appointment until arrangements are made to cover the costs of a NO SHOW appointment.

Initial _____

Insurance:

I am aware that Peter J. Callahan, PLLC does participate with some insurance but makes no promise that my insurance will pay for my treatment. **I understand that it is my obligation to obtain any required insurance pre-authorizations.** If I choose to seek reimbursement from my health care plan, Callahan Counseling Services agrees to furnish statements for that purpose. I understand that if my health insurance changes, that I am required to notify Callahan Counseling Services immediately. I also understand that Callahan Counseling Services uses a third party, NueMD, for billing.

Initial _____

Payment:

I understand that payment in full is expected at the time of service, and may be made by cash, check or money order. I agree to pay a $ 35 fee for returned checks, in addition to any bank charges incurred. In the event that a returned check incident does occur, future payments must be in the form of a cashier's check, money order, or cash.

I understand that I am ultimately responsible for all charges incurred. I understand that failure to pay on a timely basis may result in a discontinuation of services.

I understand that I am responsible for any and all charges, whether or not they are covered by my health care plan. Should I fail to pay any charge, I will be responsible for any interest and/or collections charges/fees incurred, including attorney/collection fees of up to 40% of the balance due. Further, I will be responsible for interest of 1.5% per month (18% APR) on balances overdue by 30 or more days.

My signature indicates my understanding of and agreement with all of the aforementioned terms of this contract.

_____ _____ _____

Signature and Printed Name of Client Date Signature: CCS Staff Date

_____ _____

Signature and Printed Name of Responsible Party Date

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CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS

1. To retain my legal rights as provided by state & federal laws.

2. To receive an explanation of these rights, responsibilities, treatment alternatives, and costs in an understandable manner.

3. To receive prompt evaluation and quality individualized treatment; to be fully informed about the purposes of treatment, and to participate in the development of my treatment plan.

4. To be treated kindly, with respect, and without discrimination by age, race, religion, sex, sexual preference, handicap, or national origin.

5. To not be subjected to experimental or investigational research without prior written consent of my guardian or myself.

6. To have access to my treatment records, which are kept confidential to the extent, permitted by law. This shall be limited by considerations of sound therapeutic treatment and shall be done in the presence of Callahan Counseling Services.

7. To refuse specific medications or treatment, and to be allowed access to consultation with a private physician at my own expense, for purposes of a second opinion regarding treatment except in the case of emergency procedures required for the preservation of my life/health.

8. To be treated under the least restrictive environment consistent with my condition and not be subjected to isolation or unnecessary physical restraint.

9. To be fully informed of the costs for services rendered and any related insurance provider issues or limitations.

10. To question or voice concerns about staff, services, and treatment and to request an impartial review of violations of these rights from the Human Rights Committee; to file a formal grievance; and/or to obtain legal counsel.

CLIENT RESPONSIBILITIES

While I am a client of Callahan Counseling Services, I hereby agree:

1 To report to my therapist any changes in my condition, employment, living arrangements or other support systems, or other personal situations that may affect my treatment plan.

2 To treat other program participants with dignity and respect and to preserve their confidentiality by not disclosing names during or after treatment.

3. To attend and participate in all groups and other prescribed treatment and to work sincerely toward my treatment goals.

4. To contact Callahan Counseling Services staff 24 hours in advance for cancellation of an individual or group session to avoid being charged. If I give less than the prescribed notice, or fail to call, I am aware that I may be charged ($65.00) for the missed appointment. I am also aware that insurances do not cover missed appointment fees, and that I may be responsible for missed appointment fees. Exceptions may be made for verifiable emergency situations

5. To encourage my spouse, significant other, or parents/guardians (as appropriate) to participate in the educational and support programs provided or recommended by counselor and staff.

6. To treat staff and others with courtesy and respect, understanding that I retain the right to voice objection to his behavior or file a grievance as described under client rights.

7. To abide by payment arrangements as described in the financial policy I have previously signed.

I have reviewed these Client Rights and Responsibilities and I understand their contents.

_____

Signature of Client (Parent or Guardian) Date

_____

Staff Signature Date

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CLIENT INFORMATION & EMERGENCY MEDICAL RELEASE

Name:	Soc. Sec. #:		Date:
Home Address:			Phone:
Gender:	Age:	Birth Date:	Marital Status:
Occupation:		Bus. Phone:	
Employer Name:		Position/Title:	
Presenting Problem:			
Emergency Contact:		Relationship:	Day Phone:
Address:			Eve Phone:

MEDICAL INFORMATION

Physician's Name:			Phone:
Clinic/Office Address:			
Blood Type:	I wear: ( ) Contact Lenses	( ) Glasses	( ) Hearing Aid ( ) Prosthesis ( )
Current Medications: ( ) None or List:			
Taken for what condition(s):			
Allergies to medications: ( ) None or List:			
Significant medical problems: ( ) None or List:			
Significant physical/mental disability: ( ) None or List:			
Serious childhood illnesses or head-trauma: ( ) None or List:			
Prior hospitalizations: ( ) None or List (where/when/for what):			
Family history of: ( ) Heart Disease ( ) Diabetes ( ) Cancer ( ) Alcoholism/Drug Addiction ( ) Suicide ( ) Mental Illness ( ) Stroke ( ) Schizophrenic			

RELEASE TO TRANSPORT/TREAT IN AN EMERGENCY

In the event of a medical emergency, I hereby authorize Callahan Counseling Services to perform life-saving procedures and/or to arrange for my transport to a medical facility and for emergency treatment to be administered. I do hereby release Callahan Counseling Sevrices, or any employees and/or agents, ambulance and hospital staff from all liability for injury, illness, financial obligations or other losses incurred as the result of such medical emergency.

RELEASE TO RECEIVE MEDICAL INFORMATION FROM FACILITY

In the event of a medical emergency, I hereby authorize the staff of the medical facility to which Callahan Counseling Services has transported me for emergency treatment to release information to Callahan Counseling Services for the purposes of continuity of care.

Signature of Client: Date:

Signature of Witness: Date:

BENEFITS AND RISKS OF TREATMENT

Please sign below, after reading
"Benefits and Risks of Treatment."

It is important that you understand the potential benefits and risks of counseling. This is a general statement and counselors and educators will explain any potential risks and benefits to be realized through their particular modality.

The best benefit that you can realize is a healthier quality of life, improved mental, emotional and spiritual functioning. Interpersonal relationships may also improve. Improvement in any area is highly contingent upon your commitment to working with the counselor and others on your difficult issues in life.

Risks include whatever feelings come from you in sharing with others (i.e. embarrassment, fear, and anger), the fear of looking deeply into yourself, fear of having to confront your own behavior. Another possible risk is having your insurance company or lack of financial resources cut your treatment short.

I acknowledge these risks and agree to proceed with treatment.

Signature and Printed Name of Client Date

Signature and Printed Name of Responsible Party Date

Signature of Witness Date