Date________________ Spring Hill Counseling

WELCOME

Thank you for choosing Spring Hill Counseling. To help us serve you better, please read these forms carefully and fill them out as completely as possible.

PERSONAL INFORMATION

Name:____

Date of Birth___________________ M / F MaritalStatus____________

Street Address:____

City:_________________________State:___________ Zip:_____________

Phone Number:_______________ 2nd Phone Number________________

Please indicate how you were referred to our practice:

___________Insurance company/EAP Web site

___________Pastor________________________Name of pastor/Church

___________Friend ________________________Name

___________Advertisement_________________Which one

___________Physician _____________________Dr.'s Name

___________Phone book

___________Other: ________________________

Please indicate if we can text or leave a message for you at the number you provided

_______ Yes

_______ No

Client Responsibility

You must give 48 hours notice when canceling an appointment. You will be charged for appointments that are canceled for any reason with less than 48 hours notice. **The charge will be $100 for each event.**

Spring Hill Counseling **MAY** be able to file your insurance claim for you; however, we cannot guarantee this. We also cannot guarantee payment by your particular plan. It is your responsibility to be **thoroughly** informed about your health insurance coverage and limitations for mental health services. Your insurance company has the right to audit any of your records.

You are responsible for payment of fees not covered by your insurance.

Your therapist may be contacted for emergencies by calling 615-483-7007. All phone calls longer than five (5) minutes will be billed at the rate of $30 per 15 minutes or portion thereof.

There is a fee for preparation of reports and certain types of correspondence including . Such requests must be submitted in writing with a $30 deposit. A fee will be quoted after review of your written request. Urgent requests (needed less than one week from date of request & receipt of deposit) may require an additional fee. Timothy Grimes will under no circumstances fill out **ANY** disability forms of any kind.

Your relationship with Spring Hill Counseling is protected by confidentiality; however, there are legal limits to confidentiality as in cases of suspected child abuse or when there exists a danger to self or others.

I have read and understood the above. I also understand that my treatment at Spring Hill Counseling is contingent upon the above policies and I agree to abide by them. I also understand that my treatment is completely voluntary and I consent to treatment under the terms above.

Signature:______________________________ Date:___________________________

Printed Name:________________________________

I authorize Spring Hill Counseling to charge my credit/debit card in the event of a missed or canceled appointment with less than 48 hours notice. Also for fees not covered by insurance.

Cardholder's Signature____________________________

Card # ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Expiration Date____________ Security Code_____ _____ _____ _____