

# Jetson Counseling

## Client Information, Consent and Authorization

5/6/09

Date			Client Number		
Client's Last Name	First Name	Initial	Date of Birth	Age	Marital Status
Sex	Social Security Number	Day Phone Number	Evening Phone Number	Cell Phone Number	E-mail Address
Client's Mailing Address			City	State	Zip code
<input type="checkbox"/> <b>Retired</b>					
Client's Employer/School		Business Phone	Employer/School Address		
<input type="checkbox"/> <b>None</b>					
Spouse's Last Name	First Name	Initial	Day Phone Number	E-mail Address	
Spouse's Mailing Address			City	State	Zip code
<input type="checkbox"/> <b>Same</b>					
Spouse's Employer/School		Business Phone	Employer/School Address		
<input type="checkbox"/> <b>N/A</b>					

### If The Client Is A Minor or Under Legal Guardianship

Legal Guardian's Last Name	First Name	Initial	Date of Birth	Age	Marital Status
Sex	Social Security Number	Day Phone Number	Evening Phone Number	E-mail Address	
Legal Guardian's Mailing Address			City	State	Zip code
<input type="checkbox"/> <b>Retired</b>					
Legal Guardian's Employer/School		Business Phone	Employer/School Address		
Mother's Last Name	First Name	Initial	Date of Birth	Age	Marital Status
Social Security Number	Day Phone Number	Evening Phone Number	E-mail Address		
Mother's Mailing Address			City	State	Zip code
<input type="checkbox"/> <b>Retired</b>					
Mother's Employer/School		Business Phone	Employer/School Address		
Father's Last Name	First Name	Initial	Date of Birth	Age	Marital Status
Social Security Number	Day Phone Number	Evening Phone Number	E-mail Address		
Father's Mailing Address			City	State	Zip code
<input type="checkbox"/> <b>Retired</b>					
Father's Employer/School		Business Phone	Employer/School Address		

### How did you learn about Jetson Counseling?

Family Member	Physician	Friend	Yellow Pages	Pastor	Lawyer	Other – Specify:
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Referring Physician Last Name (Please Specify)	First Name	Office	Phone Number
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## Financial & Insurance Information

I understand I must reschedule or cancel appointments **at least 24 hours in advance**, and I understand Jetson Counseling reserves the right to discuss with me the advisability of securing another care provider if I do not provide this 24 hour notice more than twice in a six (6) month period.

I further understand it is my personal responsibility to be on time for my appointment. **If I miss or am late more than 15 minutes for my appointment, I still may be required to pay for the service at current rates Jetson Counseling charges, which insurance may not cover.**

**I further understand it is my personal responsibility to know what services my insurance company may or may not pay on my behalf.** When my insurance company does not pay any portion of the charge, I may be responsible for paying the balance. I understand that Jetson Counseling cannot change information on a claim just so that claim might be paid by my insurance. I understand I must be prepared to pay my deductible and/or co-pay/co-insurance amount for that day and any account balance overdue when I check out.

I further understand if my care at Jetson Counseling requires pre-authorization, I am responsible for obtaining this pre-authorization and providing this authorization to Jetson Counseling. Jetson Counseling reserves the right to schedule an appointment after they have the necessary pre-authorization for services. For example, if my primary care physician must sign a referral card, I am responsible for getting this to Jetson Counseling before my appointment. If I don't, I may be required to pay for the services out of my own pocket.

I understand I will need to pay the client portion of all current and balance due charges at the time of service unless prior arrangements have been made. I further understand I am responsible for any and all Jetson Counseling charges not paid by my health plan, except those contractually discounted, and failure to do so may result in my account being assigned to a Jetson Counseling business associate for collection.

Signature of Responsible Party

Date

Patient's Name (Last, First, Initial)

Date of Birth

## Consents, Authorizations and Guarantees

By signing this consent I certify that I have reviewed and agree to the terms and provisions of the Thorn Counseling & Jetson Counseling Notice of Information Practices. The following is a summary of those terms and provisions. If I have any questions, I have received satisfactory answers before signing this Consent.

I understand that some things, by law, cannot be kept private. These are the exceptions to confidentiality, included but not limited to: if Jetson Counseling is ordered to testify in order to provide documents to a Court of Law, they may have to give information regarding my case without my permission. If Jetson Counseling learns that harm has been done to child or an elderly person, they may be required to inform the authorities. If Jetson Counseling learns that someone or something might be seriously harmed in the future, or that a client intends to commit an act of violence, it may be Jetson Counseling responsibility to protect me, or others by informing them and the authorities. The time being treated under a Worker Compensation claim, and/or if there are indications of a need for other specialized treatment, necessary PHI may be released to an appropriate referral provider to facilitate this treatment.

### Consent & Authorization for treatment and scheduling of appointments

I hereby authorize Jetson Counseling and its professional staff to provide treatment to myself, or the person named above for whom I am legally responsible for medical and/or financial decisions, to include the psychological assessments, group, family or individual psychotherapy, psychological neuropsychological assessments, intake interviews, and/or other mental health services. I understand I am to notify Jetson Counseling of a request to cancel an appointment 24 hours prior to the time of the appointment to be canceled. If I fail to make such a timely notification, Jetson Counseling may refuse to schedule future appointments.



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**Authorization of PHI Disclosure and Assignment of Health Plan Benefits**

I explicitly authorize and request Jetson Counseling as the holder of PHI and other information about me, or the person named above for whom I am legally responsible for medical and/or financial decisions, to release to the government or private insurance, or any other health plan that is contracted with, any information needed to determine benefits or pay claims on my behalf. This PHI specifically excludes psychotherapy notes which requires a separate authorization. I request that payment of all authorized and other health plan benefits to be made to me or on my behalf be paid directly to Jetson Counseling.

**Guarantee of Payment, Authorization of PHI Disclosure and Assignment of Patient Due Balances**

I understand and hereby guarantee I will pay the patient portion of all current and balance due charges that are due at the time of service unless prior arrangements have been made. I hereby authorize Jetson Counseling to assign any balance due charges for which I am responsible to any of its business associates for the purpose of collecting such charges. I further understand that I am responsible for any and all Jetson Counseling usual and customary charges not paid by my health plan, except those contractually discounted.

*I understand all these authorizations will remain effective for one year after I have stopped being an active client of Jetson Counseling*

<b>Failure to Obtain Consent/Authorization/Guarantee</b>	<b>Check the appropriate reason:</b>	
Indirect Treatment Relationship	Emergency Treatment	Treatment Required By Law/Regulation
Substantial Barriers and Communication	Refusal to Sign	Other
Verbal Consent (2 Signatures Required)		
Description of Circumstances:		
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Date: \_\_\_\_\_ file #: \_\_\_\_\_

Dx: \_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Marital Status : S M D W

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Status: Full Time Part Time Retired Student School: \_\_\_\_\_ Full Time Part Time

**Guarantor Information (Responsible Party):**

Patient Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Marital Status : S M D W

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Status: Full Time Part Time Retired Student School: \_\_\_\_\_ Full Time Part Time

**Payment & Insurance Information (we will need a copy of your insurance card):**

Primary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Type: ( ) Individual ( ) Group ( ) Medicaid ( ) Medicare ( ) Blue Cross ( ) Blue Shield

Group Name: \_\_\_\_\_ Group Plan #: \_\_\_\_\_ ID.#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient: Self Spouse Parent Other

Other Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Type: ( ) Individual ( ) Group ( ) Medicaid ( ) Medicare ( ) Blue Cross ( ) Blue Shield

Group Name: \_\_\_\_\_ Group Plan #: \_\_\_\_\_ ID.#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Patient: Self Spouse Parent Other

**Assignment of Benefits, Release of Information & Payment Agreement**

I request and authorize direct payment to Jetson Counseling of any government and other insurance benefits payable to me or on my behalf for services rendered by Jetson Counseling, now or in the future. At Jetson Counseling's election, I also assigned to Jetson Counseling all my rights and interest in all such insurance benefits or proceeds including, but not limited to, the right to appeal any denial of benefits or to file any lawfully authorized lien necessary to secure payment from any third party or a third-party's Insurer. I

understand that I am financially responsible for the services rendered by Jetson Counseling and agreed to immediately remit all payments received from insurance for those services. I agree to cooperate with Jetson Counseling or its agent and collecting any such benefits. This assignment shall not obligate Jetson Counseling to file any appeal or perfect any such lien and nothing herein shall relieve me from direct financial responsibility for any charges not paid by an insurer.

Financial responsibility

I acknowledge that many insurers will not pay for services that they determine to be medically necessary and that meet other coverage requirements. For example, some Insurers require prior authorization for certain services. If my Insurer determines that the services, or any part of them, are not medically necessary or fail to meet other coverage requirements, the Insurer may deny payment for that service. Notwithstanding any other provisions herein, I agree that if my Insurer denies all or any part of Jetson Counseling's charges for any reason, or if I have no insurance, I will be personally and fully responsible for payment of Jetson Counseling's charges. If my account is referred to an attorney for collection agency, I agree to pay actual attorneys fees and collection expenses.

The undersigned certifies that he/she has read the foregoing, and is the client, or the client's legal representative or his duly authorized by the client as the client's agent to execute this Authorization and Consent form and to accept its terms, except as noted below.

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Responsible Party

Date

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Patient

Date