INTAKE FORMS

Northern Sky Counseling, LLC~ Jeni Anderson, LCPC (hereinafter listed as NSC)

Thank you for choosing Northern Sky Counseling, LLC. Your initial appointment will take approximately 60 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws, and your rights. ***If you have other questions or concerns, please feel free to ask****. If you are reading through this paperwork prior to our first session please bring any questions or concerns to my attention when we meet. I appreciate your courage in seeking support with your mental health needs and that you have chosen to allow me to be a part of your process.*

CONTACT INFORMATION

Full Name:	Emergency Contact:
Preferred Phone #:	Emergency Contact #:
Email:	Relationship:

By my initials, I authorize NSC to call 911 and my emergency contact in case of emergency: _____
By my initials, I authorize NSC to provide First Aid and/or CPR if needed in case of emergency: _____
By my initials, I authorize NSC to send appointment reminders via **email** or **text** (circle preferred) _____
May I leave a phone message on "client number"? Yes No
May I text you at your "preferred phone #"? Yes No
May I email you (*please understand email is not considered "secure" via gmail)*? Yes No
If client is under 18, please list all legal parent/guardian(s) name, number, email:

_____

_____

Billing Information

How do you plan to pay for services? Please circle one of the following:

Self Pay Medicaid Private Insurance Other:_____

Please fill out all insurance information correctly in order to facilitate the filing of your claim:

Client Name:	Insured Name IF DIFFERENT:
Address:	Address:
Phone(s):	Phone(s):
Date of Birth: Age:	Date of Birth:
Gender Identity:	Gender Identity:

******Please complete the following ONLY if we are unable to photocopy your insurance card******

Insurance Company Name: _____
Address: _____
Phone:_____ Member ID: _____
Group #: _____

Billing Statement Distribution: Balance statements will be mailed to you monthly from JP Medical Billing. If you would like to make alternative arrangements to receive your billing statements, please list here:

_____

Fee Information and Payment Agreement

- ✓ By my signature below, I authorize the payment of medical benefits to NSC for services provided.
- ✓ By my signature below, I authorize the release of any medical information from my records necessary to process claims for services provided by NSC.
- ✓ I understand the fees for services will be as follows:

Service	Time Period	Fee
Diagnostic Interview/Intake Assessment	60 minutes	$160
Individual Session	60 minutes	$125
Individual Session	45 minutes	$100
Individual ½ Session in person or via phone (generally crisis check in)	30 minutes	$75

- ✓ I understand I am responsible for payment of any balance owed to NSC unpaid/not covered by my insurance.
- ✓ NSC sends electronic claims securely via JP Medical Billing.
- ✓ I understand I am responsible for notifying NSC at least 24 hours in advance if I am unable to keep my appointment. I understand that, except in illness and emergency situations, a missed appointment fee $50 will be assessed for appointments missed without 24 hours notice.
- ✓ If you are in need of a payment plan:(*otherwise leave blank*) I agree to the following payment arrangements for services provided and not paid by a third party payer:

  _____

  _____

I understand in the event that I fail to pay fees as agreed upon, I waive my right to confidentiality under Public Law 93-579 & pertinent law for the purpose of referral for collection & with respect to all other parties that may be legally liable for the obligation.

Client Signature: _____Date:_____

**If Client us under 18*
Parent/Guardian Signature(s): _____Date:_____

BILLING AGREEMENT

For co-payments & balances unpaid by insurance

FREQUENCY OF BILLING

____ *Please bill me via card info below for my co-pay at the end of each session. (Please fill in info below)*
____ *I plan to pay via cash/check at the end of each session. (Do not fill out this page)*

PAYMENTS MAY ALSO BE MADE BY:
Cash
Check **Please make checks payable to Northern Sky Counseling, LLC*

PATIENT: _____ DATE OF BIRTH:_____

CREDIT/DEBIT CARD INFORMATION (**the system does not currently support payments from Flex cards)*

CARD TYPE (ex; Visa): _____

CARD NUMBER: _____ EXPIRATION DATE:_____

CODE ON BACK:_____ **If MasterCard, 4 digit code.*

NAME AS IT APPEARS ON CARD: _____

BILLING ZIP CODE: -

Policies:

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Montana State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others, information necessary for case supervision or consultation and e) or when required by law.

*In case of Emergency: Due to my part time status I may not be available in case of emergency. If an emergency situation arises for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact 911 for those services. If danger is not imminent, the Help Center can be a good resource in crisis situations- (406) 586-3333.

CANCELLATIONS & RESCHEDULING:
If you need to cancel or reschedule an appointment, please give 24 hours advance notice as is customary in all medical/health related settings. Without appropriate notice you will be billed $50 for each "No Show". We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

A note about scheduling and unforeseen office closures- NSC is operated by Jeni Anderson, LCPC. At times, the office may be closed due to children's illnesses or school closures. At these times, NSC will make every effort to find a time to "make up" your appointment the same week where possible. I appreciate your understanding.

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist, counselor if applicable. If you wish to give consent for coordination of care, please fill out a "Release of Information" Form. If you prefer to decline consent no inform will be shared.
*If you are currently on medication, please strongly consider giving your consent for coordination of care with your medicating physician.

3rd PARTY BILLING: Billing will securely sent and processed through JP Medical Billing.
CLIENT RIGHTS
*Right to request how we contact you.
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. You have listed your communication information above; you may request that we update that information at any time.

*Right to release your medical records.
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

*Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

*Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

*Right to an accounting of disclosures.

information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release.

*Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

*Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

*Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained upon request of the therapist.

Additional information and details of your rights are described in the Privacy Policy. Please refer to that with questions. You may request a copy at any time.

Client Signature: ____ Date: __________

CONSENT FOR EVALUATION & TREATMENT OF CHILDREN/ADOLESCENTS:

I/We consent that _____________________________________ maybe treated by Jeni Anderson, LCPC. At times it may be necessary to schedule appointments during school hours. I ask for your cooperation to provide the most timely treatment for you and your children. If parents are unmarried, but share joint custody, this form must be agreed to and signed by both parents/guardians.

Signature(s)_____________________________________Date______________

Signature(s)_____________________________________Date______________

My Child/Adolescent is under the age of 18. I have read the above agreements & information and have discussed any issues or concerns with my child and the therapist.

Parent/Guardian Signature: ____________________________________ Date: __________

Parent/Guardian Signature: ____________________________________ Date: __________

-- -For Therapist-- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- --

I, Jeni Anderson, LCPC, have offered all forms, answered questions to the best of my ability and witnessed authorization given by the client and/or parent/guardian. __________________________________Date:_________