PASTORAL INSTITUTE

2022 15th Avenue | Columbus, Georgia 31901
706-649-6500 | 800-649-6446 | Fax 706-649-6521

For Office Use Only:
Date of Visit:_____
Patient #:_____
Clinician:_____
Payment Type:

Counseling Center Adult Client Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Gender: _____ Race: _____ Ethnicity: _____

Home Phone: _____ Mobile: _____ Work: _____

Email: _____

Preferred method of contact: ☐ Mobile ☐ Home ☐ Work / ☐ Voice ☐ Text ☐ Email

Employer/School: _____

Religion: _____ Church: _____

Marital Status: ☐ Single ☐ Live-In ☐ Married ☐ Divorced ☐ Widowed

Military Status: ☐ Active ☐ Veteran ☐ Disabled ☐ Retired ☐ Dependent

Spouse (if applicable): Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Employer: _____

Emergency Contact Name: _____ Relation: _____

Home/Cell Phone: _____ Work Phone: _____

Address: _____

Financial and Insurance Information

Primary Insurance: _____ Policy/Member ID #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Secondary Insurance: _____ Policy/Member ID #: _____

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

In order to file your insurance, we must have a copy of your insurance card(s).

Mental Health Information:

What has happened to cause you to seek counseling? *(continue on back if needed)*

_____

_____

_____

_____

_____

Have you received previous mental health care? ☐ Yes ☐ No

If so, what dates did you receive treatment?

_____

_____

_____

General Health Information:

Are you presently under the care of a physician? ☐ Yes ☐ No

Name of physician/psychiatrist: _____

Physician's telephone number: _____

Types and dates of surgeries: _____

_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks daily? _____

List medication(s) taken regularly: _____

_____

_____

_____ _____

Client Signature Date

SOCIAL MEDIA POLICY

Pastoral Institute staff will not accept friend requests or contact requests from current or former clients on any social networking site; i.e., Facebook, LinkedIn, etc. Adding clients and/or family members as friends or contacts on these sites can compromise a client's confidentiality and our mutual privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions, please do not hesitate to discuss the issue with your clinician.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the Pastoral Institute or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment necessary for payment of insurance claim. The insurance company is hereby authorized to pay the Pastoral Institute, Inc., basic benefits and/or major medical benefits for medical and/or treatment expenses, or to include their name on the check payable to patient for medical and/or expenses.

For Tricare Beneficiaries: **I consent to the Pastoral Institute, as a Military Treatment Facility (MTF) to send a copy of my Protected Health Information (PHI) to referring MTFs for continuity of care.**

_____ _____

Client Name (Printed) Date

_____ _____

Client Signature Pastoral Institute Witness – Initial/Date

FINANCIAL POLICY AND AGREEMENT

For those with health insurance, the Pastoral Institute will assist in filing claims and seeking reimbursement. The Pastoral Institute cannot guarantee insurance reimbursement. It is the responsibility of the patient to follow up with the insurance company to make sure they pay the claims correctly. If the insurance company does not pay within 90 days, the unpaid balance is due from the Guarantor. Some insurance coverage for mental health services requires pre-authorization. The patient must call for authorization. The insurance company will not pay for services that have not been authorized. All fees charged are the direct responsibility of the client. Payment of any and all services rendered will be expected from the guardian that escorts the patient to his or her appointments. It is the policy of the Pastoral Institute to bill for any appointment cancelled without a 24-hour notice.

Payment for co-pay or deductible is due at the time service is rendered. Accounts that become more than ninety (90) days past due may be forwarded to a collection agency. All returned checks are forwarded to Check Care for collection. Check Care adds an additional fee for collection.

Financial Agreement:

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that the statements are correct unless questioned within thirty (30) days in writing or by telephone contact with the Pastoral Institute Business Office.

_____ _____

Client Name (Printed) Date

_____ _____

Client Signature Pastoral Institute Witness – Initial/Date

PASTORAL INSTITUTE BROKEN APPOINTMENT POLICY

Your appointment time has been reserved just for you. If you find it impossible to keep your appointment time, please call us at least 24 hours in advance. Failure to call our office and cancel your appointment 24 hours in advance will result in a charge of $60.00. We offer appointment reminder phone calls and/or texts 48 hours prior to your appointment. However, this is a courtesy and you are still responsible for cancelling your appointment at least 24 hours in advance.

_____ _____

Client Signature Date

COUNSELING, CONFIDENTIALITY, PRIVACY PRACTICE AND NON-RECORDING AGREEMENT

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care. I understand that the PI is committed to quality care. I may contact the Clinical Director regarding any questions about my therapist or concerns about quality of care. I understand that the PI may call my home or other designated location and leave a message on voice mail or in person to assist the practice in carrying out health care operations, such as appointment reminders, insurance concerns, and any call pertaining to my clinical care. I have read the above and give my consent to the counseling process of the PI. I have also read and understand the Pastoral Institute's statement regarding the limits of confidentiality. In addition, I have had an opportunity to review the Pastoral Institute's Notice of Privacy Practices and have had an opportunity to obtain a copy and ask questions to seek clarification I needed about these important materials.

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

_____ _____

Client Name (Printed) Date

_____ _____

Client Signature Pastoral Institute Witness – Initial/Date

E-MAIL CONFIDENTIALITY RELEASE AGREEMENT

_____

E-mail Address

I understand that confidentiality of e-mail communications with my therapist cannot be guaranteed. I further agree that I will not attempt to extend therapy via e-mails, but only use it to conduct business of information sharing such as cancelling or confirming an appointment. Any therapeutic issues I will handle either during the therapeutic face-to-face meeting or as appropriate, by telephone in emergencies. E-mail is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular e-mail will be read and responded to within a particular period of time. Possible e-mail-related concerns can include, but are not limited to the following:

- E-mails go through several intermediate stations before reaching their destination. Someone at any point along the line could access the e-mail and even store the message contained in it.
- E-mails may remain stored in various places of a computer system and could surface at a later time.
- Computers, particularly those on DSL lines, are vulnerable to electronic eavesdropping.

Knowing the above information and considering other possibilities not yet known that could further jeopardize confidentiality, I give my permission to my therapist to respond to my e-mails according to his/her professional judgment.

_____ _____

Client Name (Printed) Date

_____ _____

Client Signature Pastoral Institute Witness – Initial/Date

INFORMED CONSENT FOR COUNSELING SERVICES AGREEMENT

It is important to Pastoral Institute's leadership and staff that we are culturally competent and aware of needs of different population groups. We strive to be respectful and inclusive of spiritual beliefs and attitudes, healing practices, and cultural/linguistic diversities. We believe as PI practitioners that this brings about positive change as we understand differing cultures among various communities and are able to work with everyone within his/her context.

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by the Pastoral Institute's (PI) staff members. I agree to collaborate with my therapist and other appropriate professional staff members of the PI for the purpose of assessment and evaluation of my current situation to work together to identify appropriate goals and methods of achieving them.

_____	_____
Client Name (Printed)	Date
_____	_____
Client Signature	Pastoral Institute Witness – Initial/Date