

**Christian Psychological Center  
3950 Central Avenue  
Memphis, TN 38111-7602**

***Information for New Clients of the Christian Psychological Center***

Thank you for giving us the opportunity of providing your psychological services. Our goal is to assist you in resolving the concerns that led you to contact Christian Psychological Center. We hope that this information helps you learn more about Christian Psychological Center and the services we provide.

Before your first appointment, please:

- Complete the **Information Sheets**
- Fill out the **Contacting You** page.
- Read through the *Christian Psychological Center Practice Policies* brochure, which outlines important information about our services, policies, and procedures. If you have any questions about this information, please discuss them with your therapist during your first session. If you are in agreement with this information, please sign the Agreement form. The agreement form attached to the actual document is for your records. The second agreement, attached to this section of paperwork, is to be signed by you and kept by our office.
- Our privacy notice, which describes how your mental health records may be used and disclosed and how you can obtain access to this information, is enclosed for your information. Please sign the *Patient Notification of Privacy Rights* document in this section to indicate that you have received this privacy notice. By federal law, we are required to secure your signature on this document indicating that you have received this information.

A few minutes of the initial appointment will be spent discussing the enclosed information with your therapist. This will give you the opportunity to ask any questions about the Center or the services you will be receiving.

***PLEASE COMPLETE ALL REQUESTED INFORMATION***

# CHRISTIAN PSYCHOLOGICAL CENTER

## Information Sheet

Chart # \_\_\_\_\_

Date \_\_\_\_\_

Therapist \_\_\_\_\_

### CLIENT'S (PATIENT) PERSONAL INFORMATION

(Legal Name) Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Preferred Name \_\_\_\_\_ Home Telephone: ( ) \_\_\_\_\_

Street Address \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell Telephone: ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married (Spouse's Name: \_\_\_\_\_) \_\_\_ Divorced \_\_\_ Widow(er)

Referred By \_\_\_\_\_

(EX: Church/Name; Internet; Insurance Co./Name; Medical Doctor/Name; Previous Patient; School/Name; Word-of-Mouth; Other/Please Specify)

Church Name \_\_\_\_\_

Person to Notify in Case of Emergency \_\_\_\_\_

Telephone Number(s): ( ) \_\_\_\_\_ Relationship to Client \_\_\_\_\_

### CLIENT'S (PATIENT) EMPLOYMENT INFORMATION (CHILD'S SCHOOL INFORMATION)

Employer \_\_\_\_\_ Employer Telephone: ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Occupation: \_\_\_\_\_

Child's School, City & State \_\_\_\_\_ Grade \_\_\_\_\_

### PERSON RESPONSIBLE FOR PAYMENT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Telephone/Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Responsible Party Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name & Address of Responsible Party's Employment:

\_\_\_\_\_

**IF CLIENT IS UNDER 18 YEARS OF AGE OR IF PARENT(S) IS RESPONSIBLE FOR PAYMENT, COMPLETE THIS SECTION**

Parent's Marital Status  Married  Divorced  Single  Widowed

Mother's Name \_\_\_\_\_ Telephone/Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Employment \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Telephone/Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Employment \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

**If divorced, have parents remarried? Mother \_\_\_\_\_ Father \_\_\_\_\_**

**Name of the custodial/primary residential party?** \_\_\_\_\_

If step-parents, please furnish names: Step-Mother: \_\_\_\_\_ Step-Father: \_\_\_\_\_

**Insurance Information**

**Primary**

Insurance \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ ID/Certificate/SS/Member Number: \_\_\_\_\_

Group # \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Relationship to Patient:  Self  Parent  Spouse  Other (*Please Indicate Relationship:* \_\_\_\_\_)

Policyholder's Date of Birth: \_\_\_\_\_ Co-Pay Amount: \$ \_\_\_\_\_ Deductible Amount: \$ \_\_\_\_\_

Insurance Effective Date(s): \_\_\_\_\_ Precertification or Preauthorization required? Yes  No

Name of Employment if Group Insurance Coverage: \_\_\_\_\_

**Secondary**

Insurance \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ ID/Certificate/SS/Member Number: \_\_\_\_\_

Group # \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Relationship to Patient:  Self  Parent  Spouse  Other (*Please Indicate Relationship:* \_\_\_\_\_)

Policyholder's Date of Birth: \_\_\_\_\_ Co-Pay Amount: \$ \_\_\_\_\_ Deductible Amount: \$ \_\_\_\_\_

Insurance Effective Date(s): \_\_\_\_\_ Precertification or Preauthorization required? Yes  No

Name of Employment if Group Insurance Coverage: \_\_\_\_\_

**Insurance Authorization to Send Reimbursement Information and Assignment**

I authorize Christian Psychological Center to furnish my insurance carriers information they may request concerning the treatment of my dependent(s) or myself. I assign to the Christian Psychological Center all payments for services rendered to my dependents or myself. I understand that I am financially responsible for any amount not covered by insurance.

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my copayment and/or deductibles are expected at the time services are rendered unless the therapist agrees otherwise. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) to which I subscribe and in which the therapist is a participating provider, I am personally responsible for the payment of 100% of the charges billed. I understand that, as a courtesy, CPC will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges.

I also understand that any court order I have is an agreement between the courts and me; this agreement is NOT with the therapist. I, therefore, am personally responsible for payment of all charges.

I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment. I realize that such action could require that the therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed.

In addition, if I have requested that CPC file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the therapist to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient: Self\_\_\_ Parent\_\_\_ Legal Guardian\_\_\_ Other (Please indicate)\_\_\_\_\_

**CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE  
OR A FEE WILL BE CHARGED.**

**CHART NUMBER:** \_\_\_\_\_

**CLIENT'S NAME:** \_\_\_\_\_

**Christian Psychological Center  
3950 Central Avenue  
Memphis, TN 38111-7602**

## **CONTACTING YOU**

Occasionally we might need to contact you for matters of a routine nature (such as changing an appointment time). Due to confidentiality, we would like your input as to where it is acceptable for us to contact you. If such contact is necessary, the receptionist will only leave his/her name and your doctor's name and our telephone number if you are not available when we call. No mention of Christian Psychological Center or the nature of the call will be given to the person who takes your message, unless we have your permission to do so.

Please complete the following, if applicable, to guide us in your wishes regarding contacting you:

- If we need to contact you, may we contact you by telephone at home?**      \_\_\_\_\_Yes      \_\_\_\_\_No  
**-May we leave a message on your home answering machine?**      \_\_\_\_\_Yes      \_\_\_\_\_No  
**-Home Telephone:** (    ) \_\_\_\_\_
- If we need to contact you, may we contact you by telephone at work?**      \_\_\_\_\_Yes      \_\_\_\_\_No  
**-May we leave a message on your voice mail at work?**      \_\_\_\_\_Yes      \_\_\_\_\_No  
**-Work Telephone:** (    ) \_\_\_\_\_ **Ext.** \_\_\_\_\_
- If we need to contact you, may we contact you on your cell phone?**      \_\_\_\_\_Yes      \_\_\_\_\_No  
**-May we leave a message on your cell phone's voice mail?**      \_\_\_\_\_Yes      \_\_\_\_\_No  
**-Cell Number:** (    ) \_\_\_\_\_

Periodically Christian Psychological Center sends information by mail regarding the Center, new services being offered, or request for completion of anonymous surveys in order to evaluate the quality of our services. Do you wish to have your name and address placed on this mailing list?

- \_\_\_\_\_ **Yes**, I request my name and address be placed on this mailing list.  
\_\_\_\_\_ **No**, I prefer not to participate.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Christian Psychological Center, Inc.  
3950 Central Avenue  
Memphis, TN 38111-7602**

**Telephone: 901-458-6291  
FAX: 901-323-4848**

AGREEMENT:

I have read, understand, and accept the policies, procedures, and conditions outlined in Christian Psychological Center's Practice Policies brochure. These include the areas of:

- General information about the Center
- The nature of psychotherapy and the benefits/risks
- The nature and limits of confidentiality
- Financial considerations for services rendered

One copy of this agreement is for you to keep and the other will be placed in your file at Christian Psychological Center.

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Patient

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Date

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Parent or Guardian if Patient is a Minor

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Date

## PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”); the keeping and use of patient records (“privacy rules”); and, storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. Our Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; and, as such, you will find we will do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

I understand and have been provided a copy of Christian Psychological Center’s Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

\_\_\_\_\_  
Print Name of Patient/Client

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Signature of Patient/Client *or* Parent if Minor *or* Legal Charge

\_\_\_\_\_  
Date

Relationship to Patient/Client of Person Signing Notification: \_\_\_\_\_

If Legal Charge, describe representative authority: \_\_\_\_\_