Miracles Counseling Centers, INC
(P) 704-664-1009/ (F) 704-664-1029

111 Kilson Dr. St.201
Mooresville, NC 28117

7480 Waterside Loop Rd. #204
Denver, NC 28037

We are so glad you are here!

Child/Adolescent Intake

Child's name:____

Parent/Guardian 1: ______________________________Parent/Guardian 2:______________________________

Address:____City:______________________Zip:______________

Parent's Telephone: Home:__________________ Cell:____________________ Work:_______________________

Child's of Birth:__________________________ SS#:______________________ DL#:________________________

Emergency Contact: ____Telephone:____________________________

Child's School: ____

Referred By:____

Guardian's Email address:____

Payment Information

Check Type of Insurance: ☐ Private ☐EAP ☐None

Insurance Company: ____Policy Holder:_________________________

Relationship to Insured:______________________________________ Insured's D.O.B.: ______________________

Policy #:__________________________________Group #:______________ Insured's SS#:_____________________

EAP Authorization Number____________________________________ EAP Phone #:________________________

Financial Responsibilities

- Co -payments and deductibles are due at the time of service.
- I hereby assign payment of insurance benefits directly to Miracles Healing Centers. While Miracles Healing Centers will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay.
- It is my responsibility to inform my therapist of any changes to my insurance coverage. I am financially responsible for any lapses in insurance coverage.
- While miracles counseling centers will provide me with a courtesy insurance benefits check, I am still responsible for understanding what my insurance covers and verifying this coverage.
- It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges.
- I will be billed for phone consultations, letters, or medical record copies at the therapists standard rate by 15 minute increments.
- If my portion of the bill is not paid within 90 days from the last date it was incurred a letter will be sent giving you 14 days to pay my account or to arrange for a payment plan. If I do not respond I will be sent to collections.
- If accounts are sent to collections, a 25% balance charge will be incurred.
- Returned check fees are $35.00 and the check amount.
- You will be charged $75 for missed appointments without providing 24 hour notice of cancellation.

By signing below, I consent to services and to participating in treatment provided by Miracles Counseling Centers. I affirm I understand and agree to the financial policies as described above of Miracles Counseling Centers.

____ ____________________

Client/Guardian Signature **Date**

Consent for Treatment of Minors

1. I (legal guardian name)__________________________________ give my consent to Miracles Healing Centers, Inc. and my therapist, to conduct psychotherapy with (minor name) _____________________________________. My relationship to the client is (parent, uncle, guardian, etc.)_____________________. My signature below indicates that I am notified that all material discussed during psychotherapy sessions is confidential and can be released only with the permission of the minor child.

2. In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs, sex, or high risk behaviors. I will accept my therapist judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well-being.

3. **To be Completed if Custody Arrangement Exists:**
   It is the responsibility of the consenting parent to inform the other legal parent of the participation in counseling services and its progress. It is also the responsibility of the consenting parent to provide their therapist with the legal custody documentation, as well as advising your counselor of any changes to your custody agreements. I acknowledge I have (please check) ☐ sole legal custody ☐ joint/shared legal custody

In the case of parents who have joint legal custody, please provide the name and contact information of the other parent. Miracles Counseling Centers Counselors believes that it is best clinical practice that an effort is made to connect with both parents. **We understand there are certain circumstances where this may not be appropriate or may not be possible and this can be discussed with your treatment provider.** Please provide the following information of the other parent, if known:

____

Name Address Phone

Does this parent have (please check) ☐ sole legal custody ☐ joint/shared legal custody?

By signing this, I acknowledge that I have legal custody and that the information I am sharing is true and accurate. My treatment provider has the right to discontinue treatment if information is not provided accurately.**By signing below , I acknowledge my responsibilities and consent to treatment of my minor child:**

____

Signature (Guardian) Date

____

Printed Name Relationship Date

MIRACLES COUNSELING CENTERS, INC

134 Professional Park Dr., Suite 400
Mooresville, NC 28117

518 Highway 16N
Denver, NC 28037

(P) 704-664-1009 (F) 704-483-3782

Notice of Privacy Practice Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to….

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers why may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

This facility participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our offices and online at NCHealthConnex.gov. You may also contact our Office at (704) 664-1009.. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Client Name (please print):____

Signature:____

Date:____

Name/Relationship to Client (please print):____

Miracles Counseling Centers, Inc.

Patient Rights and Responsibilities

You have the right to:

- to be treated with dignity and respect
- to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- to have their treatment and other patient information kept private. Only by lawmay records be released without patient permission.
- to access care easily and in a timely fashion.
- to a candid discussion about all their treatment choices, regardless of cost, or coverage of their benefit plan.
- to share in developing their plan of care.
- to the delivery of services in a culturally competent manner.
- to information about the organization, its providers, services, and role in the treatment process.
- to information about provider work history and training.
- to information about clinical guidelines used in providing and managing their care. to know about advocacy and community groups and prevention services.
- to freely file a complaint, grievance, or appeal, and to learn how to do so.
- to know about laws that relate to their rights and responsibilities.
- to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's right and responsibilities policy.

You have the responsibility:

- to treat those giving them care with dignity and respect.
- to give providers the information they need, in order to provide the best possible care.
- to ask their providers questions about their care.
- to help develop and follow the agreed upon treatment plans for their care, including the agreed upon medication plan.
- to let their provider, know when the treatment plan no longer works for them.
- to tell their provider about medication changes, including medications given to them by others.
- to keep their appointments. Patients should call their providers soon as possible i thy need to cancel visits.
- to let their provider, know about their insurance coverage and any changes to it.
- to let their provider, know about problems with paying fees.
- not take actions that could harm others.
- to report fraud and abuse.
- to openly report concerns about the quality of care.
- to let their provider, know about any changes to their contact information (name, address, phone, etc.)
- understand and help develop plan and goals to improve their health.

I have read and understood my rights and responsibilities.

____

Client Signature Date

Credit Card on File Authorization Form

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file.

I authorize Miracles Counseling Centers, Inc., to keep my signature and card information on file and to charge therapy session fees (individual, group, workshops, couples, family or other), or for any appointments with a therapist that are not cancelled within 24 hours of the scheduled appointment time to be charged to my credit, charge or debit card or flex spending account as filled out below for therapy services provided to:

____

(Therapy Client's Name: Please Print)

I understand that his authorization is valid until canceled in writing. I understand that thought this information is secured in my client file, and is unlikely to be tampered with. I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services or materials will normally be posted to my credit/debit/flex card account within 72 hours of each session date. Additionally, I agree that the card listed below may be charged by Miracles Counseling Centers, Inc. in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CD's DVD's) that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee is incurred I am responsible for these fees. **Initial**_______________

Please fill out the details as indicated below:

Card Holders Name:(exactly as it appears on the card)

____

Card Number____C V V _____________

Expiration Date____

Card Holders Signature____ Date: _____________________