

Miracles Counseling Centers, INC

111 Kilson Dr. St.201
 Mooresville, NC 28117
 (704) 664-1009

5641 Poplar Tent Rd. Suite 204
 Concord, NC 28027

7480 Waterside Loop Rd. #204
 Denver, NC 28037
 (704) 483-3783

We are so glad you are here!

Individual Intake

Client's Name: _____ Todays Date: _____

Address: _____ City: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Birthday: _____ SS#: _____ DL#: _____

Emergency Contact: _____ Telephone: _____

Client's Employer/School: _____

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. Cash payment fees are: \$160/assessment, \$135/individual sessions, and \$145 couples/family sessions.
- 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 \$100 for missed appointments without providing 24 hour notice of cancellation.
- I give permission for text message reminders of my appointments to be sent.

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 Signature

Date



Miracles Counseling Centers

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

518 Highway 16N
Denver, NC 28037

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 who 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 NCHHealthConnex.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 NCHHealthConnex.gov/patients.

HIPAA Privacy Notification: Email is not a secure method for transmitting confidential information. If you want to make me aware of important information or clinical issues, please call me at 704-664-1009 ext. 22. This message and accompanying documents are covered by the Electronic Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by e-mail, and delete the original message.

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 by 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 law may 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 as soon as possible if they 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 quality of care.
- to let their provider know about any changes to their contact information (name, address, phone, etc.)
- understand and help develop plans 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 though 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 chargeback 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: _____