GHP Counseling Services
222 Government Ave, Suite E
Niceville, FL 32578
ghpcounselingservices.com
Phone/FAX (850) 659-3550

New Client Information

Name: _____ _____ _____
First Last MI
DOB: ___ / ___ / _____ (mm/dd/yr) SSN: _____ - ____ - _____
Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____
E-mail:_____
May we leave detailed message: Y / N
Please circle which one: Voicemail/Email/Cell/Text

Please check one: ☐ Married ☐ Divorced ☐ Single ☐ Widow ☐ Child

How were you referred to us? ☐ Internet ☐ Friend ☐ Insurance Co. ☐ Professional

☐ Other: _____

INSURANCE INFORMATION

Primary Insurance:

Name of Insured Policy Holder: _____

Name of Insurance: _____

Contract Number: _____ Group Number: _____

Authorization Number: _____

Begin Date: _____ Expire Date: _____

Number of Sessions: _____ Provider: _____

Secondary Insurance (if any):

Name of Insured Policy Holder: _____

Name of Secondary Insurance: _____

Contract Number: _____ Group Number: _____

General Information Regarding Insurance:

Medical insurance coverage is a contract between you and your insurance company. Neither GHP nor your therapist is a party to your contract, and has no standing in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

If you have medical insurance, we are happy to file initial claims on your behalf to your medical insurance for the services provided by our office. It is important to understand that we are typically required to provide a diagnosis to your insurance company in order to be paid.

To help us process your claim correctly, please make sure that the information you provide to our office on the patient information form remains accurate and current. If there is a change in your insurance information, it is your responsibility to let us know immediately. We will submit secondary insurance if you indicate that you want us to perform this service on your behalf.

A SPECIAL NOTE Situations such as separation or divorce can affect your insurance coverage, and it is your responsibility to let your therapist know about this kind of development immediately.

Deductibles, Co-Payments and Co-insurance:

Co-payments are due at the time service is rendered. Co-insurance and deductibles vary for each insurance policy, and we can only approximate the percentage covered by each plan. Payment of the estimated portions due at the time of service.

Authorizations:

A copy of your insurance card is required at the time of initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company, and we must contact them to verify the necessity of an authorization. If a copy of the card is not on file at the initial service and the claims denied for "no authorization," you will be responsible for the payment.

Whether you are using insurance or are self-pay, please understand that you are ultimately responsible for any payments or outstanding bills. Accounts that are past due will be turned over to our collection agency and may be reported to credit bureaus. We

are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.
I acknowledge that I have read and agree to the about Financial Policy.

_____ _____
Client or Responsible Party's Signature Date

CANCELLATION/MISSED APPOINTMENT AGREEMENT

GHP Counseling Services has a 24-hour cancellation policy. If you do not call to cancel your appointment within 24 hours of your scheduled appointment, or you fail to show up for your appointment, you will be charged a Late Cancellation/No-Show fee accordingly by your therapist. For example, your therapist may charge a penalty fee for a late cancellation or broken session, or you may be billed for the entire session.

OTHER SERVICES PROVIDED BY GHP

Be aware that most insurance companies will not cover services such as court appearances, report preparation, record copying, etc. If you anticipate needing this type of service, discuss it with your therapist, and please be aware that you may incur unreimbursed (out of pocket) expenses.

HIPPA COMPLIANCE

GHP has a policy that meets government standards for HIPPA (Health Insurance Portability and Accountability Act) which covers privacy of all medical information. If you desire to read or have a copy of our privacy policy, please request this.

My signature indicates that I have been offered a copy of the Privacy Policy and gives this practice the right to file, on my behalf, for insurance payments.

_____ _____
Client or Responsible Party's Signature Date

UNATTENDED CHILDREN/NO BABYSITTING AVAILABLE

I understand that due to the nature of GHP Counseling Services privacy and liability issues that there will be no children allowed in the office unattended unless they are a client seeing the counselor. The office manager working is not responsible for your child when you are in therapy session. Thank you for your cooperation in this matter.

_____ _____
Client or Responsible Party's Signature Date

CREDIT CARD PRE-AUTHORIZATION Form

I authorize GHP Counseling Services to keep my signature on file and charge my credit card as follows:

Please initial below:

_____ I understand that my credit card number will remain on file for the duration of my treatment. Should there be any change with the card listed on file to charge, it will be my responsibility to provide a new number immediately.

_____ My card will automatically be charged a $50 fee for the scheduled day of service should I no show my appointment or not give a 24+ notification of cancelation of my appointment. The only exception that would be in the event of an emergency, which would be addressed at that time.

_____ If the credit card on file does not go through, then the balance will need to be paid prior to scheduling your next appointment.

Complete card information below and sign, thank you.

Credit Card type: _____ Visa _____ MC _____ Discover _____ American Express

Card #_____

Expiration Date: _____ Security Code 3 digit_____

Cardholder Name (Printed): _____

X_____
Signature of Card Holder (or Guardian, if under the age of 18)

Date: _____

ONLY FOR OFFICE USE: _____
_____
_____
_____