Welcome to Christiana Counseling....

Please take a few moments to review the following policies and procedures:

- Office staff are available Monday - Thursday 9:00 a.m. to 4:00 p.m. and Friday 9:00 a.m. to 2:00 p.m. If you call at other times, you have the option to leave a message in the voice mail or speak with our answering service. In case of an emergency situation, please discuss with your therapist their procedure for handling this situation. If you cannot reach anyone, please call the Psychiatric Crisis Line of the Medical Center of Delaware at (302) 428-2118, or Crisis Intervention at (302) 577-2484 or 9-1-1.

- Your appointment time is reserved. Please contact our office at (302) 995-1680 within 24 hours to cancel or you will be billed **a missed appointment fee of $75.00**. Your insurance will NOT pay for missed appointments.

- **Copays are due at the time of your visit.** We accept Visa, MasterCard, Discover and cash. **NO PERSONAL CHECKS PLEASE.**

- We bill your insurance company as a courtesy. You are responsible for payment of copays and deductibles. If your insurance company fails to make payment of your claims within 45 days, you will be responsible for payment in full.

- Please be aware that if you do not make timely payments on your account and develop a balance past 45 days, your account will be sent to Berks Credit and Collections and your treatment will be terminated. You will be responsible for paying all charges assessed by the collection agency.

- Information that you share with us is confidential. Exceptions include behavior that is homicidal or suicidal or dictated by state law (e.g. child abuse). However, if you use your insurance to pay for services, we must share your information with insurance company representatives. Your insurance company expects us to communicate with your primary care physician. Your signature below grants us permission to do so.

I have received the HIPAA Notice of Privacy Practices.

PLEASE • NO FOOD • NO DRINKS • CELL PHONES OFF

I HAVE READ AND ACCEPT THE TERMS STATED ABOVE.

_____

Signature Date

_____

Print your name here

CHRISTIANA COUNSELING AND PSYCHIATRIC ASSOCIATES
5235 W. WOODMILL DRIVE SUITES 47 & 48 WILMINGTON, DE 19808

PATIENT'S NAME _____ DOB _____ AGE _____ *M or F*

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____ ALT. PHONE _____ SS# _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PH # _____

IF PATIENT IS UNDER 18 YEARS OF AGE LIST PARENT OR GUARDIAN:

NAME _____ PHONE _____ DOB _____

HOME ADDRESS _____ SS # _____

INSURED'S NAME _____ DOB _____ *M or F*

ADDRESS OF INSURED _____

INSURED'S EMPLOYER _____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY NAME & PHONE # _____

GROUP/ACCT # _____ ID/MEMBER # _____ SS # _____

SECONDARY INSURANCE: POLICY HOLDER _____ DOB _____ *M or F*

ADDRESS OF INSURED _____

INSURED'S EMPLOYER _____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY NAME & PHONE # _____

GROUP/ACCT # _____ ID/MEMBER # _____ SS# _____

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE # _____

LIST CURRENT MEDICATIONS: _____

LIST MEDICATION ALLERGIES: _____

HAVE YOU BEEN IN THERAPY BEFORE: Y OR N IF YES, WHEN/ WITH WHOM? _____

HOW WERE YOU REFERRED TO CHRISTIANA COUNSELING? _____

THE PATIENT/GUARDIAN/INSURED IS RESPONSIBLE FOR THE COPAYMENT AT THE TIME OF SERVICE AS WELL AS THE PORTION OF THE BILL WHICH IS NOT COVERED BY THE INSURANCE COMPANY.

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____