

- Hergert & Associates Family Counseling Services -

252 S. Central Avenue, PO Box 887, Marshfield, WI 54449
Ph (715) 384-7579 Fax (715) 384-8131

Therapist: Steve Johnson, LPC
Date: _____

Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Employer _____ Work Phone _____

May we contact you at home? Yes ___ No ___ Work? Yes ___ No ___ Referral Source: _____

DOB: _____ Age _____ Sex _____ Soc. Sec. # _____

Marital Status: _____ Spouse's Name _____ DOB: _____

Spouse's Soc. Sec. No. _____ Employer _____ Work Phone _____

Children: Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Email Address: _____ Create a "Security Question Answer": _____

(Your email address is used for appointment reminders, and the security question answer is used to read confidential responses.)

[Please record your SQA. If you email Steve with personal information, he will use the SQA to ensure that only you can open the reply.]

Primary Insurance Coverage

Subscriber Name _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Ph _____ DOB _____

Employer _____

Insurance Co Name _____

Insurance Co Phone _____

Policy No./Employee ID# _____

Secondary Insurance:

Subscriber Name _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Ph _____ DOB _____

Employer _____

Insurance Co Name _____

Insurance Co Phone _____

Policy No./Employee ID# _____

I hereby authorize insurance payment directly to Hergert & Associates for services performed at this clinic.
I hereby authorize Hergert & Associates to release any medical information necessary to process claims.
I may be charged \$45 for missed appointments and for appointments cancelled less than 24 hours in advance.
If any other payor source denies benefits, I will be held responsible for the amount due.

I recognize and accept personal responsibility for payment of the deductible, co-pay, or other amount for any balance outstanding after payment of insurance benefits.

In the event any unpaid balance is placed for collections with any third party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee of 33.33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by Hergert & Associates to collect amounts owed under this agreement.

Such costs include, but are not limited to, court costs, service/filing fees and other costs of collections.

A late fee of \$3.00 will be added each month for any account more than 60 days overdue.

Client/Guardian Signature _____ Date _____

Please make sure you read and sign the back of this form

CLIENT RIGHTS and HIPAA INFORMATION

I understand that the following is a summary of my rights as a client of Hergert & Associates:

The right to prompt and adequate treatment environment.

The right to be treated with respect and dignity.

The right to confidentiality of conversations and records.

The right to refuse to be filmed or taped.

The right to participate in the development of any treatment plan, including benefits, effects and method of treatment.

The right, upon request, to receive information regarding alternative programs or methods of treatment.

The right to refuse any treatment, including medications.

The right to have access to my treatment record after discharge, or during treatment if facility director approves it, and to have access at all times to records of medications I take or any treatment I receive for physical health reasons.

The right to refuse, or to give informed consent, to participate in drastic treatment or in experimental research. Informed consent shall remain in effect until formal discharge from the treatment program, unless revoked by me in writing.

The right to file a grievance.

If I believe that one of my Client Rights may have been violated, the agency's complaint investigator will investigate the matter and attempt to find a resolution, if the complaint is validated. If I wish to file a complaint, I may request a complaint form from any staff member of the agency.

I am encouraged to contact my therapist regarding any concerns or problems I may have during my treatment and after my discharge. I further understand that I may, at any time, request resumption of services. I understand my therapist may be consulting with a psychologist regarding my case.

I hereby give my consent to treatment at Hergert & Associates according to the agreed upon treatment plan.

Hergert & Associates cannot be responsible for children left unsupervised in the waiting room. Please make prior arrangements for childcare.

Client/Guardian name (print) _____

Client/Guardian Signature _____ Date _____

I acknowledge that I have received written notice of my HIPAA related rights / Privacy Practices that describe how and for what reasons my protected health information (PHI) may be disclosed to others. I understand its content and I am aware of my rights and responsibilities as a client of Hergert & Associates Family Counseling Services.

_____ Initial Here