

THE CENTER FOR CHRISTIAN COUNSELING, LTD.



Welcome to ***The Center for Christian Counseling (C3)***! We hope and pray that your life will be forever changed by your experience here as God's Holy Spirit works through our Counselors and changes hearts through the truth and power of His Word.

As you begin your counseling experience here at **C3**, we want you to be aware of a few things that are essential if the counseling you receive is to be transforming. They are as follows:

- ♥ The counseling you will receive here is drawn 100% from God's Word, and does not use or integrate secular ideas at all.
- ♥ Biblical counseling, when done with authenticity, is always "heart focused". Your Counselor will explain this in detail as you go along, but the crux of this truth is that unless a person's heart changes, there can never be any real, permanent change / transformation / healing in a person's life.
- ♥ Heart change is not about getting more "head knowledge". While the accurate application of God's Word is essential to good Biblical counseling, Scripture is only as effective in changing lives as it effects that person's turning away (repentance) from our sinful nature (Jer. 17:9). While teaching and applying God's Word is central to the Biblical counseling you will receive here at **C3**, in the end this process is much more about "intense discipleship" aimed at changing our client's hearts and lives.

Your Counselor will endeavor, in a Spirit of Truth and Love, to help you choose to change your heart so that you may come to possess healing and the abundant life that Christ desires so very much for you to have (John 10:10). If you are ready to examine your own heart and change it wherever the Lord convicts you to do so through the counseling process, then the Fruit of His Spirit (Gal. 5:22) will reign in your life.

We are excited to be involved in this journey with you, and we pray that your heart is ready for **Jehovah Rophe**, the God of Healing, to touch your life, your marriage and your family!

Jerry Meade, LCSW
Founder and President
The Center for Christian Counseling, Ltd.
www.c3christiancounseling.com

Main office: 6021 Morriss Road, Suite 112 ♦ Flower Mound, Texas 75028

Phone: 469.635.2200 ♦ Fax: 972.874.0523

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and

209 N Industrial Blvd., Suite 237

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**QUESTIONS TO ASK YOUR INSURANCE COMPANY
BEFORE YOUR SCHEDULED APPOINTMENT DATE:**

1. Do I have Out of Network Mental Health benefits in my plan?

2. Do I have a deductible; if so, how much is it? _____
Can it be combined with my medical deductible in order to meet it? How
much of it have I met so far? _____
3. What is the percentage that my insurance pays _____
and what is the percentage that is my copay _____?
4. How many visits are allowed per calendar year? _____
5. Do I need to be pre-certified or pre-authorized (call before being seen by
counselor)? _____ If so, how many visits allowed before I have to call
again? _____
6. What address does C3 need to use to send out-of-network Mental Health
Claims? (need complete street address, city, state, and zip)

7. What is my insurance company's Payor ID number for electronic claim
submission by C3? _____
8. Effective date of my policy: _____ Is my policy on a
calendar or anniversary year? _____

PLEASE NOTE: The fee for your initial visit with the *Center for Christian Counseling Ltd* is required to be paid in full to your Counselor at the time of your visit. With submission of this form at that time, you may then begin using your insurance benefits with our Counselors for your subsequent visits after you have met your annual deductible.

C³ CENTER FOR CHRISTIAN COUNSELING LTD
 Telephone: (469) 635-2200 Fax: (972) 874-0523
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 Flower Mound ♥ Bedford ♥ Frisco

Client Information

Today's Date: _____ **Counselor:** _____ **DX:** _____

Client's Name: _____
First Middle Initial Last

Address: _____
 City: _____ State: _____ Zip: _____

Social Security #: _____ **Date of Birth:** _____ **Email:** _____

Phone: (____) _____ (____) _____ (____) _____
Home Work Cell

Spouse /Guardian/Parent Information (please circle one):

Name: _____
First Middle Initial Last

Address (if different from client): _____

Social Security # _____ **Date of Birth** _____ **Email:** _____

Phone: (____) _____ (____) _____ (____) _____
Home Work Cell

Other Information: **Dependents:**

Name	Relation	DOB
Name	Relation	DOB
Name	Relation	DOB

Church Affiliation: _____ **Referred by:** _____

Insurance Information

(Note: Please present insurance card with this form to be photocopied. Thank you.)

Name of Insured: _____ **SSN:** _____

Insured's DOB: _____ **ID#:** _____ **Group#:** _____

Insurance Carrier: _____

Address: _____

CITY: _____ **ST:** _____ **ZIP:** _____

Benefit/Eligibility Phone Number: (____) _____ **Deductible:** _____

Insured's Employer: _____

Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Phone:** _____

I authorize the release of any medical or other information necessary to process this claim.

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.

Insured's or Authorized Person's Signature

Insured's or Authorized Person's Signature

The Center For Christian Counseling Ltd

Welcome to *The Center For Christian Counseling Ltd!* It is our deepest desire to help you with whatever problem has brought you here through the truth and power of God's Word. He is the Creator and Designer of all things, and there is no human situation for which He does not have a solution. Together we will work towards that solution based on the truth that is provided to us in Scripture.

Confidentiality: Everything spoken here at **C3** is protected by the confidentiality statutes of the State of Texas. That means *The Center For Christian Counseling Ltd (C3)* will in no way disclose any information without your written consent except in the following situations: (a) If you threaten grave bodily harm or death to yourself or another person, your counselor is required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to your counselor your knowledge of the physical or sexual abuse of a minor child by an adult or of an elder (over 65) by an adult, your counselor is required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if your counselor is required by a court of law (court order) to turn over records to the court or is ordered to testify regarding those records.

Supervision: The staff of *The Center for Christian Counseling Ltd* operates as a team to improve the quality of counseling. Your session may be discussed with your counselor's clinical supervisor, but only with your permission.

Appointments: Counseling sessions are 45-50 minutes. For counseling to be effective several things are required: commitment to the process through faithfully attending appointments; completing "homework assignments" between sessions; establishing clearly defined goals (the counselor will help do this in the first session); and a willingness to accept the truth, as found in God's Word, and integrate it into your life. *The Center for Christian Counseling Ltd* requires that 24 hours notice be given if canceling an appointment becomes necessary. You will be billed for the session if less than 24 hours notice is given; emergency situations may be discussed with your counselor.

Financial Policy: The standard fee for services provided by *The Center For Christian Counseling Ltd* is \$100.00 for the initial session and \$90 per session thereafter. Payment is due when services are rendered, at the end of each session. **C3** does not currently participate in managed care agreements with insurance companies. **C3** will agree to file insurance claims on out-of-network mental health benefits if the client has applicable insurance coverage. **The client is responsible for any co-payments, deductibles, and non-allowed charges. It is the client's responsibility to know what their insurance policy covers and to make sure the deductible is met.** The issue of fee and reimbursement will be discussed and determined by the client and counselor during the first session. *The Center For Christian Counseling Ltd* will provide an invoice to the client at each session.

Please let your Counselor know if you have any questions.

If client is under 18, I _____ (please print), have legal custody and give my consent for counseling of the above named minor. If client is a child/children of divorce, *The Center For Christian Counseling Ltd* will need a copy of the divorce decree showing the legal custodian of the child/children.

Signature of Parent or Guardian

All members of your family who are involved in counseling need to sign below, indicating understanding of these policies and procedures.

ACKNOWLEDGED:

Date: _____ **Client's Signatures:** _____

Counselor: _____

NOTICE OF PRIVACY PRACTICES

(Client's Copy)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or other practitioner.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within The Center for Christian Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of The Center for Christian Counseling, such as releasing, transferring, or providing access to information about you to other parties.

2. We may disclose to a family member, other relative, a close personal friend of yours, or any other person identified by you, the health information directly relevant to such person’s involvement with your care or payment related to your health care.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission that is above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your counseling notes. “*Counseling notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners, the board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

PATIENT RIGHTS

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described previously). On your request, we will discuss with you the details of the accounting process.

QUESTIONS OR COMPLAINTS

For more information about our privacy policy or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may complain to us using the contact information listed at the end of this Notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will provide you with that address to file your complaint upon request.

Contact Officer: Jerry Meade
Telephone: 469-635-2200
Address: 6021 Morriss Road, Suite 112
Flower Mound, TX 75028

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

Signature

Date

For office use only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Specify below)
-
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INFORMED CONSENT FOR INTERN CLIENTS

Thank you for choosing **The Center for Christian Counseling Ltd** for your counseling needs. Your counselor is a professional who has completed a Masters level program meeting state requirements for licensure as a professional counselor. In the interim, your counselor is required by the state to complete a several thousand-hour internship; upon completion of which he/she must then pass a state-issued test. **He/She currently holds a temporary license to counsel, issued by the state of Texas and is under supervision by a fully licensed therapist at The Center for Christian Counseling Ltd.** This means that your sessions and their contents will be discussed between the counselor and his/her supervisor from time to time.

I understand the intern status of my counselor and the supervisory relationship between my counselor and their supervisor.

Signed _____

Witness _____

Date _____