Enoch Ministries Counseling Center

New Child Patient Form

First Name:_____ Middle Name:_____ Last Name:_____

Preferred Name:_____

Street Address:_____ Town:_____ State: _____ Zip:_____

Phone #: (H):_____(W):_____ (Cell):_____

Email:_____

SS#:_____ DOB:_____ Age:_____

Mother's Name:_____ Contact #:_____

Father's Name:_____ Contact #:_____

Father's Address:_____

Marital Status of Parents:_____ Legal Guardian:_____

Step-Parent Name(s) if applicable: _____

Siblings (1st names and ages)_____

_____

Emergency Contact:_____ Phone #:_____

Relationship:_____

Primary Insurance Company:_____Employer:_____

Insurance ID #:_____ Insurance Group #:_____

Name of Insured Person:_____ Insured Person's SS#:_____

Secondary Insurance Company:_____Employer:_____

Insurance ID #:_____ Insurance Group #:_____

Whom may we thank for referring you?:_____ Telephone #:_____

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Signature Authorization

Name of patient: _____ Date:_____

LIFETIME SIGNATURE AUTHORIZATION

I request that payment of authorized benefits be made on my behalf to the treating clinician at Enoch Ministries Counseling Center assigned to my patient for any services rendered by her to myself or my legal dependent named above as "patient." I authorized the release of any medical, psychological, mental health, or substance abuse information necessare to determine these benefits o the benefits payable to related services. I understand that I am physically responsible for all charges incurred in providing services for the aforementioned patient.

Patient/Authorized Signature: _____ Date:_____ Witness:_____

CONSENT FOR TREATMENT

I, furthermore, give consent for mental health care deemed necessary to accurately diagnose and treat patient's condition. I further consent to any communication about patient's condition between the practitioners located at Enoch Ministries Counseling Center as deemed necessary to provide appropriate mental health care. I understand that any information relating to this patient will be maintained confidentially.

Patient/Authorized Signature: _____ Date:_____ Witness:_____

DECLARATION OF AUTHORITY TO CONSENT FOR TREATMENT

I hereby assert that I have legal authority to consent for the individual listed above as "patient"

Patient/Authorized Signature: _____ Date:_____ Witness:_____

INFORMED CONSENT OF CROSS COVERAGE CARE

I understand that the clinicians at Enoch Ministries Counseling Center provide cross coverage for one another for the clinical care of their patients/clients. I hereby grant consent for this cross coverage of care and any communication whether it be written, verbal, electronic, and/or faxed about my condition or that of my legal dependent named above as "patient" between any of the clinicians at Enoch Ministries Counseling Center deemed necessary to provide appropriate mental health care.

Patient/Authorized Signature: _____ Date:_____ Witness:_____

UNDERSTANDING OF FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for any financial obligations that are incurred for the mental health services provided to me or my legal dependent names above as "patient". This legal obligation remains binding regardless of my insurance coverage of my insurance company's decisions regarding payment. I understand that ultimately the cost for any services rendered for clinical care is mine. I furthermore give consent to release any information needed for collection of payments for these provided services to any collection agency deemed necessary by my treating clinician.

Patient/Authorized Signature: _____ Date:_____ Witness:_____

AUTHORIZATION FOR APPOINTMENT REMINDERS

Appointment confirmation will be delivered via email to the address that you provided.

Patient/Authorized Signature: _____ Date:_____ Witness:_____

NAME OF INDIVIDUAL COMPLETING THIS FORM:

Last Name:_____ First Name:_____ Middle Initial:_____

Contact #:_____ Relationship:_____

Enoch Ministries Counseling Center

Medical Information

Primary Physician (s):_____

Please briefly describe the problem(s) for which you are currently seeking help:_____

_____

All current medication (Names and dosages):_____

_____

Medication allergies:_____

Pharmacy used:_____ Phone #:_____

Check any that apply (now or in the past):

Ulcers ☐	Sleep Apnea ☐	Sexual Problems ☐	Appendicitis ☐
Emphysema ☐	Hepatitis ☐	Diabetes ☐	Mumps ☐
Kidney Disease ☐	Seizures ☐	Cancer ☐	Birth Trauma ☐
Liver Disease ☐	Prostate Problems ☐	Head Injury ☐	Heart Murmur ☐
Asthma ☐	Sickle Cell Anemia ☐	Cholesterol Problems ☐	Pneumonia ☐
Arthritis ☐	Migraines ☐	Heart Disease ☐	Ear Infection ☐
Glaucoma ☐	Pregnancy ☐	Parkinson's Disease ☐	Chicken Pox ☐
High Blood Pressure ☐	Stroke ☐	Memory Problems ☐	Other:
Fibromyalgia ☐	Menstrual Problem ☐	Anemia ☐	_____

Surgery (type/date):_____

Current or Past Difficulties with Drug or Alcohol Usage:_____

Past Drug or Alcohol Treatment (Type/Date):_____

Do you smoke or use tobacco products?_____ Previously?_____

Type/Amount:_____ Do you drink alcohol in any form?_____

If currently smoke or drink, would you like assistance to stop these habits?_____

Other information that might impact patient's safety in a farm setting

Has client had Tetanus Shot:_____ Date:_____

Please indicate if patient has a problem and/or surgeries in any of the following areas:

Auditory: ☐	Pulmonary: ☐	Learning Disability: ☐	Coordination: ☐
Visual: ☐	Neurological: ☐	Mental Impairment: ☐	Balance: ☐
Speech: ☐	Muscular: ☐	Emotional/Psychological: ☐	Seizure: ☐
Cardiac: ☐	Orthopedic: ☐	Tactile Sensation: ☐	Other:
Circulator: ☐	Allergies: ☐	Incontinence: ☐	

Please comment on any of the above problems and/or surgeries checked in the box above:_____

_____

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Psychiatric Information

Previous Psychiatrist(s) or Therapist(s):_____

_____

Previous Psychiatric Hospitalizations (dates and causes):_____

_____

_____

Please list any Previous Psychiatric Medications which you have taken previously (Names/Dates):_____

_____

_____

Past history of physical abuse? (Yes or No) Specifics:_____

_____

Past history of sexual abuse? (Yes or No) Specifics:_____

_____

Family History of Psychiatric Illness

Check any that apply (now or in the past):

Panic Disorder:	☐	Psychiatric Hospitalizations:	☐	Other:	
Suicide:	☐	Schizophrenia:	☐		
Depression:	☐	Anxiety:	☐		
Anger Management Problems:	☐	Dementia:	☐		
Bipolar Illness (Manic Depression):	☐	Alzheimer's Disease:	☐		
		Substance Abuse (Alcohol or Drugs):	☐		

I attest that all of the information I have given above is accurae and complete to the best of my knowledge.

Authorized Signature:_____ Date:_____

Witness:_____ Date:_____

Reviewed by Clinician:_____ Date:_____

Enoch Ministries Counseling Center

PATIENT NAME:_____SS#:_____

- The policies and procedures of this office have been created in an effort to improve service and to minimize inconvenience to our patients. It is our hop that by familiarizing you with these policies in advance, we may prevent misunderstanding and potential confusion or other difficulties.
- OFFICE HOURS: The office is open from 8:00 A.M until 5:00 P.M. Tuesday through Friday.
- APPOINTMENT: Visits are by appointment only. However, if an urgent need should arise, we will make every effort to see you that day if possible. During business hours, please contact the office at 706-881-2141. If we are busy, please leave a message and your call will be returned. If you are unable to wait for a call back or your need is emergent, please proceed to your nearest hospital emergency department or call 911 for assistance in a life-threatening event.
- FEES: Psychotherapist fees are: Initial office visit-$150.00, 45-50 minute office visit-$95.00, 20-25 minute visit-$60.00, and extended sessions, consultation and assessment are charged at a higher rate. Fees may be adjusted periodically. If this occurs, a notice will be posted in the front office.
- Should you need to cancel an appointment. TWENTY-FOUR HOURS ADVANCE NOTICE will be required. This allows us time to schedule another patient for that period. A CHARGE WILL BE MADE FOR MISSED APPOINTMENTS WITHOUT TWENTY-FOUR HOUR NOTICE OF CANCELLATION.
- Payment in full is required at the time of service unless other arrangements have been made in advance. A $35.00 service charge will be made for all returned checks.
- INSURANCE POLICIES: Please be aware that some insurance companies require the insured patient to contact them in advance of any scheduled visit to obtain pre-authorization for services. You are solely responsible for meeting this or any other obligation of your contract with your insurance company prior to the time of your visit. If you have questions about how to obtain pre-authorization, our office staff will be happy to assist. Your insurance co-payments and deductible fees are required in full at the time of service.
- Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we will be happy to file a claim for your visit on your behalf. The ultimate responsibility for payment, however, remains with you. Accordingly, any account balance over thirty (30) days old will be billed directly to you. Should your account have to be collected through a collection agency or an attorney, you shall also be responsible for all reasonable attorney's fees and all costs of collection. Please be aware that all unpaid balances will be referred to a collection agency if you fail to fulfill your financial obligations.
- Please be aware that Enoch Ministries is a non-profit organization that provides absolutely no clinical care to any individual. All the clinicians practicing at the site of Enoch Ministries are solo-practitioners and are in private practice. Every clinician at this site contracts management services independently from Enoch Ministries. All treatment decisions made and care provide are sole the responsibility of the individual clinician whose services you are receiving. There is no clinical affiliation between the professionals practicing at Enoch Ministries. Any exceptions to this policy will be posted in the lobby for your review at any time. If you have any questions regarding this information, please ask you clinician or ask to speak to Enoch Ministries office staff.
- TREATMENT EXPECTATIONS: Many things affect the success of treatment The severity of the problem, the match between the doctor/clinician and patient, and the motivation of the patient among other factors affect the length of treatment. Please discuss with your doctor/clinician your feeling about treatment and whether it is meeting your needs.
- Typically, the decision to terminate therapy is made by mutual consent of doctor/clinician and patient. In the event that you decide to discontinue treatment without notifying your doctor/clinician, it is assumed that the therapeutic relationship terminates 30 days after your last visit.
- CONSENT TO TREAT: I give consent to Leigh Ellen Ertle and the practicing clinicians/practitioners doing business at Enoch Ministries Counseling Center as of this date to provide any psychiatric and/or mental health/substance abuse care deemed necessary to accurately diagnose and treat my condition.
- CONSENT FOR RELEASE OF INFORMATION BETWEEN THE SOLO PRACTITIONERS AT ENOCH MINISTRIES COUNSELING CENTER: I further consent, for purposes of clinical discussion and emergent care needs, to any communication about my condition between them and referring clinician and any other treating physician or mental health provider deemed necessary to provide appropriate psychotherapy care. (This communication may occur in verbal, written, faxed, or electronic form.) I understand that any information released regarding my care will occur upon my consent and written request unless otherwise specifically required by law (for example: child abuse, imminent threat of danger to self or others, Judge's order, etc.). This consent for release of information wil be considered valid for a period of one year unless I choose to withdraw my consent by explicitly notifying my doctor/clinician.

A photocopy of this form shall be considered as effective and valid as the original.
Please read this information carefully and discuss any question you may have. A copy of this form is available for your records.

I have fully read, understand and agree to the above policies and consents.

Patient/Guardian Signature:_____Date:_____
Print Name of Patient or Guardian_____Witness:_____Date:_____