Stress Management Center at Fernview

1115 Dunlap Road Anderson, SC 29621 / P.O. Box 1424 Anderson 29625 Phone 864-225-0792 Fax 864-226-3968

First Name _____MI_____ Last Name_____
Date of Birth: _____ SS#_____ Marital Status: M/S/W/D
Gender Identity:_____Cell Phone _____ Alternate Number _____
May we leave a detailed message: Yes or No
Street Address_____
City_____ State_____ Zip _____
Email Address_____
EMERGENCY CONTACT_____ **Phone**_____
Who is financially responsible for this account?_____
Relationship to Patient and contact information: _____
Employer/School Information of Client_____
Occupation_____Years_____
Address_____State_____Phone_____

Insurance/ Payment Information Relation to Client_____
Contact Number: _____
First Name _____MI__ Last Name_____ DOB_____
StreetAddress_____City_____State____Zip_____

Insurance Filing and Payment:

We are a provider for most major insurance companies. Be sure to provide your correct, current insurance information. Client/ Guardians of minors are required to pay their coinsurance or copayments at or prior to or at time of service. It is the responsibility of the patient/guardian to make payment for any non-covered services received which may include but is not limited to: phone consultations, records requests, professional letter requests, clinical documents, crisis support, late/missed appointment fees. I understand that payment for my portion of insurance, cash pay or other services is due on or prior to the day of service, unless other payment arrangements have been made at the office.

Signature of Client /Representative_____Date_____

Stress Management Center (Please initial beside all the following)

_____Unpaid balances over 90 days are eligible for outside collection.
_____Initial Assessment does not guarantee a follow-up appointment at this practice.
_____Social media. LLR banned communication on social media. Contact them through the office ONLY.
_____Virtual & Crisis appointments are filed with insurance Crisis sessions will be filed under insurance
_____Tele consultations & support are billed as applicable to time required & degree of need
_____Text messaging is not sanctioned with provider/s. A fee of 25.00 for each test may be applied
_____If needed we will work with a client to create payment plans to prevent accounts being in arrears
_____There will be a $30 charge for declined payments with each payment attempt by card, check or transfers
_____EAP information needs to be provided BEFORE the initial appointment.
_____Applicable charge documentation/ clinical paperwork that is completed by clinical provider/s
_____We are happy to reschedule appointments if necessary. A fee of $75 for cancellations within 24 hours of appointment. A full charge is applied to account for appointments that are no show/ no call.

The office reserves the right to dismiss any patient who is non-compliant regarding treatment and/or office policy/ procedures. Our office transmits information electronically. If information is received in error by a third party, I absolve this practice of all liability. I understand information will be provided to Insurance companies for payment of my treatment. I give / do not give my permission to Stress Management Center to share my psychological/psychiatric diagnoses or release information/records to the following agency/ person(s):

Name: _____Phone_____ Purpose/ Relationship_____
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I understand my medical records may contain psychological/psychiatric, substance abuse and/ or other information shared as part of my medical records for treatment. I will need to sign an authorization to release any information except to my Insurance Provider

Signature of Client/ Representative _____Date _____
Signature Parent or Legal Guardian_____Date_____
Signature Parent or Legal Guardian_____Date_____

Medical/Mental Health/Medication

Primary Care Physician/s _____May we contact: Yes: _____ No: _____

Health Family Medical/Mental Health History

Current Medications: _____
Drug Allergies_____ Food Allergies_____
Smoking___ Packs per day_____ How long _____ Coffee_____ Other_____
Caffeine_____Type_____Amount total_____ Drugs _____
Type_____ Frequency_____Alcohol_____Type_____
Frequency____Amount____Sleep Disturbance: Snoring___ Awakening___ Drowsiness

I agree to treat and release. I have read and understand these forms and all questions have been answered. I give my consent to treatment and to speak with a clinician. I also give my specific provider authorization to discuss my care with other interoffice clinical providers .**Signature of Client_____Date_____**
Signature Parent or Legal Guardian_____Date_____

Universal Medications Please attach a list or provide to provider current medications
Name of Medication/s_____Dosage_____Prescriber_____Condition:
_____

In cases of couples/ family counseling, all those who attend need to sign and date stating they understand the confidentiality of the sessions. For individuals under 18 years of age, both parents will need to sign for the minor in cases of joint custody.

Print Name _____Sign_____Date_____
Print Name _____Sign_____Date_____
Print Name _____Sign_____Date_____
Print Name _____Sign_____Date_____

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Card Authorization

Stress Management Center to honor our agreement for services provided both in person or virtual,requires a payment method of HSA, credit or debit card on reserve in our confidential/ encrypted system to cover copays or session fees unless other agreements/ arrangements are made with office staff prior to your session. We are partnered with First Citizens bank and pay additional fees for your convenience. Please complete all fields. You can cancel this authorization at any time by contacting our office. This authorization will remain in effect until canceled. For any payments made to your account(s) there will be a 3.5% charge except for some HSA cards which are exempt for each transaction using debit/credit cards. We work with every client to help them receive the support services they need to embrace a healthy lifestyle. We are to conference if needed and honored to serve you.

If you prefer to come in person to our office to share this information you are welcome.

Credit Card Information

Card Type: __ MasterCard __ VISA __ Discover __ AMEX ___ HSA/FSA _____

Cardholders Name (as shown on card):

_____Expiration Date (MM/YY): _____

Card Number: _____Security Code:_____

Zip code associated with billing address: _____

I, _____, authorize Stress Management Center at Fernview to charge my credit card above for co pays and/or balances. I understand my information will be saved to our encrypted EHR system for future transactions on my account and will not be removed unless our office is notified.

Customer Signature _____Date_____

Payment is due the day of treatment. A 2.5% adjustment may be added to any unpaid balances.Patients with health insurance are responsible for providing current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we will bill your insurance company for you, but we cannot guarantee payment of your claim. The balance is your responsibility whether your insurance company pays your claim or not. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. And failure to collect copayments and deductibles from patients can be considered a breach of contract. Please be aware that some services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit. If your account has an unpaid balance, we can provide you with a statement.

If you are unable to pay your balance in full, please contact our billing office at the Stress Management Center. We will work to assist you in establishing a payment plan to allay interest or declined fees from accruing due to non payment. Accounts that remain unpaid after 90 days may be referred to a collection agency. You will be responsible for all costs associated with the collection of your account, including but not limited to attorney and collection agency fees. The Stress Management Center reserves the right to change this payment policy at any time. By seeking services from the Stress Management Center or any affiliated clinical provider you are agreeing to the terms of this payment policy.

Signed:_____Date_____