

Stress Management Center at Fernview

1115 Dunlap Road Anderson, SC 29621 / P.O. Box 1424 Anderson 29625 Phone 864-225-0792 Fax 864-226-396

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____
Date of Birth: ___ / ___ / ___ SS# _____ Marital Status: M/S/W/D
Gender Identity: _____ Cell Phone _____ Alternate Number _____
Occupation: _____ Employers Name: _____
May we leave a detailed message: Yes No
Street Address _____
City _____ State _____ Zip _____
Email Address _____ May we email you? Yes No

EMERGENCY CONTACT

Emergency Contact Name _____ Phone _____
Relationship to Patient _____

MEDICAL / MENTAL HEALTH / MEDICATION INFORMATION

May we contact your Primary Care Physician(s)? Yes or No
Primary Care Physician(s): _____ Phone: _____

Health & Family Medical / Mental Health History:

Food Allergies: _____ Other Allergies: _____

Smoking: Yes or No If yes, how many packs per day? _____ How long: _____

Alcohol Use: Yes or No Frequency: _____ Amount: _____

Drug Use: Yes or No Frequency: _____ Amount: _____

Caffeine (Coffee/other): Type: _____ Frequency: _____ Amount: _____

Sleep Disturbances: Snoring Awakening Drowsiness Other: _____

Current Medications:

Name of Medication: _____

Prescriber: _____

Condition Treated: _____ Dosage/Frequency: _____

FINANCIALLY RESPONSIBLE PARTY

(If different from patient)

Name _____ Phone _____

Relationship to Patient _____ Date of Birth: ___ / ___ / ___

Address _____ State _____ Zip _____

INSURANCE / PAYMENT INFORMATION

Policy Holder's Name: _____ Policy Holder's Date of Birth: ___/___/___
 Primary Insurance Company: _____ Relationship to Client: _____
 Policy Number: _____ Group Number: _____

Insurance Filing and Payment Policy:

We are a provider for most major insurance companies. Please provide your correct and current insurance information. Clients/guardians of minors are required to pay their co-insurance or co-payments at or before the time of service. It is the responsibility of the client/guardian to pay for any non-covered services, which may include, but are not limited to, phone consultations, record requests, professional letters, crisis support, and late/missed appointment fees.

Payment Policy:

Payment for your portion of insurance, cash pay, or other services is due on or before the day of service, unless other payment arrangements have been made with our office.

Collection Policy:

Unpaid balances that have been outstanding for 90 days or more may be referred to an outside collection agency.

Acknowledgement and Agreement

I have read, understand, and agree to the above payment and insurance policies.

Signature of Client /Representative _____ **Date:** ___/___/___

Please initial each statement below:

	I understand that an initial assessment does not guarantee a follow-up appointment at this practice.
	I acknowledge that communication with providers via social media or text is strictly prohibited. All communication must occur through the office. A \$25 fee may be applied for each text message attempt.
	I understand that virtual and crisis appointments will be billed to my insurance as applicable.
	I understand telehealth consultations and support will be billed on time and need.
	I understand that a fee will be charged for letterhead paperwork/forms, medication refills, and prior authorizations.
	I understand that payment plans may be arranged to prevent my account from becoming overdue.
	I understand that a \$30 fee will be charged for each declined payment attempt (card, check, or transfer).
	I understand that all required documentation must be provided before my initial appointment.
	I understand that appointments may be rescheduled if necessary. A \$75 fee applies for cancellations within 24 hours. Full session fees will be charged for no-shows or missed appointments without notice.
	I understand that the office reserves the right to dismiss any patient who is non-compliant with treatment or office policies.

	I acknowledge that the office transmits information electronically. If information is inadvertently received by a third party, I absolve the practice of liability.
	I understand that information will be provided to my insurance company for payment for my treatment.

Notice of Privacy Practices (HIPAA)

Your Health Information is confidential and protected by law. By signing below, you acknowledge receipt of our Notice of Privacy Practices, available upon request.

Signature of Client/Representative: _____ **Date:** ___/___/___

Authorization for Release of Information

I give / do not give (circle one) my permission to the Stress Management Center to share my psychological/psychiatric diagnoses or release information/records to the following agency/ person(s):

Name: _____ Phone _____ Purpose/ Relationship _____
 Name: _____ Phone _____ Purpose/Relationship _____
 Name: _____ Phone _____ Purpose/Relationship _____
 Name: _____ Phone _____ Purpose/Relationship _____

Medical Records Release Acknowledgment

I understand my medical records may contain sensitive information, including psychological/psychiatric or substance abuse details. I understand that I must sign a specific authorization to release any information except to my insurance provider.

Signature of Client/Representative: _____ **Date:** ___/___/___

Signature of Parent or Legal Guardian (if applicable): _____ **Date:** ___/___/___

Consent for Treatment and Release

I have read and understand these forms. All of my questions have been answered. I give my consent to treatment and to speak with a clinician. I authorize my provider to discuss my care with other interoffice clinical providers as needed.

Signature of Client: _____ **Date:** ___/___/___

Signature Parent or Legal Guardian (if applicable): _____ **Date:** ___/___/___

For Couples/Family Counseling

All participants must sign and date the document below to acknowledge their understanding of session confidentiality. For minors (under 18) in joint custody, both parents must sign.

Print Name _____ Sign _____ Date _____
 Print Name _____ Sign _____ Date _____
 Print Name _____ Sign _____ Date _____
 Print Name _____ Sign _____ Date _____

Card Authorization

To honor our agreement for services provided (in person or virtual), the Stress Management

Center requires a payment method (HSA, credit, or debit card) on file in our confidential, encrypted system to cover co-pays or session fees unless other arrangements are made with office staff prior to your session.

We are partnered with First Citizens Bank and pay additional fees for your convenience. You may 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 per transaction (some HSA cards are exempt). We work with every client to help them receive the support services they need to embrace a healthy lifestyle.

If you prefer, you may provide this information in person at our office.

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: _____

Authorization

I, _____, authorize Stress Management Center at Fernview to charge my credit card listed above for copays and/or balances. I understand my information will be securely stored in our encrypted EHR system for future transactions on my account. Payment is due the day of treatment, and a 2.5% fee may be added to any unpaid balances. While we will bill your insurance as a courtesy, you are responsible for providing current insurance information and for any balances not covered by your insurer. All copays and deductibles must be paid at the time of service. Some services may not be covered by insurance, and you are responsible for payment in those cases.

If you are unable to pay your balance in full, please contact our billing office to discuss a payment plan. Accounts unpaid after 90 days may be sent to collections, and you are responsible for associated fees. The Stress Management Center may update this policy at any time. By receiving services, you agree to these terms.

Date: _____

Signature: _____

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