CCW Counseling

Personal and Insurance Contact Information

Date:_____

Client name:_____Date of birth:_____

If a minor, the name of the responsible party or guardian:_____

Home address:_____City:_____Zip:_____

Phone:_____home Phone: _____cell

Relationship Status: Married_____Single_____Divorced_____Widowed_____

Responsible party employer: _____Occupation:_____

Business address:_____Phone:_____

Name of spouse:_____Employed by:_____

Family physician:_____Phone:_____

Emergency contact other than spouse:_____

Relation to you:_____Phone:_____

Name of primary insured:_____DOB:_____SSN:_____

Name of primary insurance:_____

Insurance ID#:_____Insurance Group#:_____

Name of secondary insurance:_____

Insurance ID#:_____Insurance Group#:_____

Victims Compensation Program #:_____

I authorize CCW Counseling to furnish information to insurance carriers concerning my diagnosis and treatment and assign to CCW Counseling all payments for services rendered to my dependents or me. I am also responsible to pay CCW Counseling for any co-payment dictated by my insurance carrier.

Signature:_____Date:_____

Informed Consent for Treatment

I, _____, consent to be treated by Caleen Wieg, LMFT. I understand that I may refuse any or all services if I so choose. I also understand that my involvement is essential to the success of my treatment.

Length of treatment will depend on the time it takes to meet the agreed upon treatment goals. Risks of therapy could range from disruptions in life, initial emotional distress, and the possibility that treatment may be ineffective. The benefits of treatment may include feelings of emotional wellness, contentment, or a sense of having more control over one's life.

The fee for service is **$80 dollars per 50-minute session** and is payable on the day of service unless arrangements have been discussed prior to the treatment session. There is a 24-hour cancellation notice policy prior to scheduled appointment times. Non-emergency cancellations less than 24 hours prior to appointment times and "no shows" may be billed $50.

In case of emergency, client may call Caleen Wieg, LMFT, at (559) 760-7463. In extreme emergency, the client may be instructed to call 911 or go to the nearest emergency facility.

Client signature:_____Date:_____
Print client's name:_____

Parent/Guardian/Conservator Signature:_____
Print Guardian's name:_____Date:_____

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Notice of Privacy Practices

I understand that the records regarding my treatment are the property of Caleen Wieg, LMFT, and that such records or other information about my treatment may be released only upon my written authorization or that of my conservator or representative. I also understand that under certain situations, medical information and records are not confidential: 1) If I reveal information that leads to suspect child or elder abuse, 2) If I'm suspected of being a threat to myself or others, or 3) If my illness or the medication I take influences my ability to drive safely. I understand that in these situations, Caleen Wieg, LMFT, is required by law to notify the proper authorities or make decisions to ensure my safety and the safety of others.

I agree that medical records created as a result of treatment by Caleen Wieg, LMFT, may be disclosed to providers of health care or other health care professionals or facilities for the purpose of diagnosis or treatment upon written consent of the client or their legal guardian, representative, or conservator.

I understand that Caleen Wieg, LMFT, may need to obtain my medical records from previous providers to assist in diagnosis and treatment. CCW Counseling will obtain medical records only with written consent by the client, their guardian or conservator. I understand that part of treatment may include referrals to other groups or healthcare providers to assist in meeting treatment goals.

This information is provided to you in accordance with laws regarding the handling of your healthcare information. By signing this form I acknowledge I received a copy of CCW Counseling "Notice of Privacy Practices".

Client signature:_____Date:_____
Print client's name:_____

Parent/Guardian/Conservator Signature:_____
Print Guardian's name:_____Date:_____

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Fee Agreement

The fee for service is $80 per 50 minute session which is payable on the day of service unless arrangements have been discussed with the therapist prior to the treatment session.

CCW Counseling is contracted with the following insurance carriers and will bill for services:

Blue Cross Blue Shield of California
Department of Social Services
Magellan Health Care
MHN (Managed Health Network)
Victims' Compensation Program

Unless other arrangements have been made, clients will be responsible for billing their own insurance company. CCW Counseling will provide a "super bill" that can be submitted by the client to the insurance carrier for reimbursement.

There is a 24-hour cancellation policy prior to the scheduled appointment time. Non-emergency cancellations less than 24 hours in advance and "no shows" will be billed $50.

I agree to the above conditions as they apply to me.

Client Signature_____
Print Client Name:_____
Date:_____

Parent/Guardian/Conservator (if client is a minor or under conservatorship)
_____
Print Name:_____
Date:_____
Name of Minor:_____