STONE CITY COUNSELING, Inc.

2325 Q Street
Bedford, IN 47421
Phone (812) 279-HOPE (4673)
Fax (812) 279-4672

Probation: YES NO
Probation County: _____
Probation Officer: _____

ADULT INTAKE PAPERWORK

First Name: _____ Last Name: _____ Middle Initial: ____ DOB: _____

Street, City, State, Zip: _____

(No post office boxes allowed-if you require your statements mailed to a PO BOX please inform staff)

Email address **IF** you would allow contact via email: _____

Phone number(s): _____ _____ **Number we can text/leave message:** _____

Emergency Contact Name/relationship: _____ Telephone No: _____

Primary Care Physician Name: _____ **Phone Number:** _____

!! Appointment Reminders!!

_____ **YES, I would like a PHONE CALL reminding me of my appointments. Please use the home phone number I listed above.**
_____ **YES, I would like a TEXT MESSAGE reminding me of my appointments. Please use the cell phone number I listed above.**

Name of Insurance: _____ **ID Number:** _____

Name of Insured: _____ **Date of Birth of Insured:** _____

INSURANCE/PAYMENTS:

We file claims with your insurance company **as a *courtesy*. All deductibles and co-pays are due at the time of service or you will be asked to reschedule.** Concerning a minor child, **payment is due at the time of service**, regardless of which parent is responsible. We make no guarantee as to what your insurance benefits are. We forward information we receive in our attempt to preauthorize. You are responsible for any remainder balances that insurance does not cover. In the event that we did not collect the appropriate amount at the time of service and/or co-payment is not received you will be invoiced and expected to pay within 30 days. All payments not made within 30 days of dated invoice will incur a 5% monthly billing fee and will be subject to collections. **Initials:** _____

Self -Pay rates are optional when insurance is not available. Evaluation $120.00, Family $83.00, Family w/o patient $70.00, Individual $70.00. Rates are subject to change. **Initials:** _____

SCC only accepts Medicaid as a **PRIMARY INSURANCE ONLY.** If at any time Medicaid becomes a secondary insurance ***and you wish to receive or continue receiving treatment at SCC***, although you have been given the names of other providers in the area that would / will accept your Medicaid as a secondary, you understand that you will be responsible for the amount not covered by your primary insurance. **Payment for services and balances owed are to be paid PRIOR to services being rendered. Initials** _____

No Call/No Show and Late Cancellation Consequences

As of January 1, 2008 a **$35.00 Late Cancellation fee will apply for any** appointment cancelled less than 24 hours prior to appointment time or for any scheduled appointment that you fail to attend. The fee will be due prior to your next appointment; in addition, as of January 1, 2011, if arriving **10 or more minutes later than your scheduled appointment time**, we will ask you to reschedule. It is considered a Late Cancellation and a $35.00 fee will be due prior to your next appointment. Certain insurance companies/contracts forbid such fees. In these cases more than one late cancellation or late arrival for an appointment may result in termination of therapy.

If you **no show / no call for (2) appointments it is at the clinician's discretion to reschedule in the future or refer you to another facility. If you have rotating weekly appointments you can lose your assigned time. Initials:** _____