DFTC, Inc. CLIENT INFORMATION

Dx:_____
(office use only)

Client Name:_____ Date of Birth:_____ Sex: M or F

Street Address:_____ City:_____ State____ Zip_____

Social Security #: ____-____-____ Marital Status: M S D W Spouse Name:_____

Parents: Father_____ Mother:_____
(if client is child)
Step-mother_____ Step-Father:_____

Describe custodial arrangement (if applicable): _____

Non-custodial parent : Name:_____ Address:_____

City:_____ State:_____ Zip:_____

		Whose #?	OK to Call?	OK to leave message?
Home Phone:	_____	_____	Yes No	Yes No
Home Phone:	_____	_____	Yes No	Yes No
Work Phone:	_____	_____	Yes No	Yes No
Work Phone:	_____	_____	Yes No	Yes No
Cell Phone:	_____	_____	Yes No	Yes No
Cell Phone:	_____	_____	Yes No	Yes No

Address where we can send information: Name:_____ Relationship to Client_____
(If different than above)
Address:_____ City:_____ State:____ Zip:_____

Any special requests for leaving messages or for billing arrangements? Yes No If Yes, please describe:

_____

_____

INSURANCE INFORMATION

All statements will be sent to Policy Holder unless otherwise indicated

Policy Holder _____ DOB:_____ Relationship to Client_____

Street Address:_____ City_____ State_____ Zip_____

Policyholder's Social Security #: _____-_____-_____ Employer:_____

Insurance Company Name:_____ Insurance Phone:_____

Group #:_____ ID#_____

PLEASE READ AND SIGN THE FOLLOWING

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS: Person or Organization granted this consent:

Denver Family Therapy Center, Inc.
4891 Independence, Suite 165
Wheat Ridge, CO 80033
THERAPIST:_____

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities).
With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.
These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.
You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.
You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.
This consent is voluntary: you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____
Signature of Client or Personal Representative Date

Relationship of Personal Representative to the client: _____

AUTHORIZATION OF ASSIGNMENT OF BENEFITS & DFTC FINANCIAL AND BILLING POLICIES
PLEASE READ AND INITIAL:

_____I/we authorize direct payment of insurance payments from my insurance company to Denver Family Therapy Center for services rendered.

_____ It is understood that the responsible party should obtain an authorization number prior to the initial therapy session depending on the insurance company policy, otherwise the responsible party will accept responsibility for payment of full cost of services rendered.

_____For office and home based psychotherapy, medication consultations, psychiatric evaluations and other professional services, payment is required at the time services are rendered unless prior arrangements are made. I/we agree to be responsible for all charges for professional services rendered on behalf of the identified client, including any charges not reimbursed (copay, deductible and coinsurance, collateral services) by my insurance carrier unless a special arrangement has been agreed upon in writing.

_____ It is further understood that I/we will be financially responsible for missed appointments unless a 24-hour notice is given prior to scheduled appointment.

_____ It is understood that Denver Family Therapy Center does not bill to secondary insurance company and that I/we will be responsible for charges after the primary insurance has made payment.

_____It is understood that any checks written to Denver Family Therapy Center that are returned from the bank for any reasons, will incur a charge from Denver Family Therapy Center.

_____ It is understood that if I/we change address, phone number, insurance companies or any other pertinent information, I/we will notify Denver Family Therapy Center as soon as changes are made.

_____ It is understood that if I/we change insurance companies and that information is not given to Denver Family Therapy Center I/we will be responsible for any charges for professional services incurred.

My/Our signature(s) below indicate that I/we understand DFTC financial policies and certifies that I/we are financially responsible for services provided. I/we will be responsible for any collection or attorney fees or court costs associated with the use of outside agencies required for collection of my/our account.

Client Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Denver Family Therapy Center, Inc.
4891 Independence St. #165
Wheat Ridge, CO 80033
Phone 303-424-1373

Email: denverfamilyther@qwestoffice.net

NO CALL NO SHOW/LATE CANCELLATION POLICY

There is a charge for clients who miss their scheduled appointment or cancel their appointment less than 24 hours prior to the scheduled appointment.

The charge for a missed or late cancelled appointment is $80.00.

I have been notified of this policy.

Responsible Party Signature: _____date: _____

I understand that co-pays are due at the time of service.

Signature: _____

Please provide the e-mail address where Denver Family Therapy Center, Inc. can submit a statement:

_____

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY NON-SECURE TRANSMISSIONS

This consent form is for the communication of Protect Health Information that Denver Family Therapy Center, Inc. (hereinafter "DFTC") may transmit without the written authorization of the client as described in the Uses and Disclosure section of DFTC's Notice of Privacy Policies and Practices.

I,_____, hereby consent and authorize DFTC to communicate my protected health information through the following non-secure transmissions (please initial your choices):

_____ Cellular/Mobile Phone this includes text messaging
(Please Insert Cell Phone Number_____)

(Second Cell Number If Needed_____)
_____Unsecured Email
(Please Provide Your Email _____)
Please Circle One: Work Personal
_____Other Media (example Skype)
(Please describe:_____)
_____I do not wish to have my protected health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, I cannot guarantee that those communications will remain confidential. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a unintended third-party.

I, _____, understand that DFTC may use and disclose the following protected health information without my written authorization. However, I consent to DFTC transmitting the following protected health information by the above selected electronic communications (please initial your choices):

_____Information related to scheduling
_____Information related to billing and payments
_____Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____Information related to DFTC's operations
_____Other Information. Please Describe:_____

_____ _____
Signature of Client/Parent/Legal Guardian DATE

TO PAY WITH A CREDIT CARD

This card is a: debit card credit card flex spending card

(please circle one)

- CREDIT CARD NUMBER

  __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

- EXPIRATION DATE __ __ / __ __

- DOLLAR AMOUNT YOU INTEND TO PAY $_____.____

- 3 DIGIT SECURITY CODE FOUND ON THE BACK OF YOUR CARD __ __ __

- PRINT YOUR NAME AS IT APPEARS ON THE CARD

_____

- ADDRESS & ZIP CODE WHERE THE CREDIT CARD BILL IS SENT

_____

I authorize DENVER FAMILY THERAPY CENTER, INC. to charge my account

Cardholder Signature: _____Date:_____

Please keep my credit card number on file and charge my card:

___ each time I come for a visit or automatically.

___ charge my credit card this time only.