BreakThru
Counseling and Consulting, P. C.

DATE: ________

PROSPECTIVE CLIENT DATA FORM

WELCOME!! Please share with us the following information. We can then help you determine if it would be a good fit to work with Dr. Warner. If you have any questions you can contact us at: (678)775-6704. **You have choice in how you send us this form. You can complete it online and then email it back to us or, you can download the form and fax it to (678)954-6616 or, mail it to: Breakthru Counseling & Consulting, P.C., 6340 Sugarloaf Parkway, Ste. 200, Duluth, Georgia, 30097.** Also, we need to alert you if you choose below to communicate with us by electronic transmission (texts, cell phone, faxes and/or emails) you assume the risk this may pose to client confidentiality. In this day and age of hackers, there is no 100% guarantee of confidentiality for any of us via electronic transmission. Thus, privacy of electronic transmissions cannot be assured. However, we'll do our utmost to preserve your confidentiality on our end. Upon receipt and review of your information, we'll contact you to discuss setting up an appointment. Please make sure you give us a day and night time phone number. We look forward to serving you!

Information on person filling out this form:
Name: __________________________ Home phone: _________________ Work phone: __________________
Cell phone: ______________________ Email: ____
Address: ____ City: _________________ State: ____ Zip: ______
OK to leave a voicemail at? Home: ______ Work: ______ Cell: _______ Email ok to send? _______
Who referred you to BreakThru? ____
What is your relationship to the prospective Breakthru client? ____

Prospective Client Information: **PLEASE PRINT CLEARLY**

Prospective Client's name: ___________________________ Date of Birth: ________Email: _________________
Home phone: _______________________Cell phone: _________________ Work phone: __________________
OK to leave a voicemail at? Home: ______ Work: ______ Cell: _______ Email ok to send? _______
Spouse: ______________________________________ Spouse's Work phone: _________________________
Parent (If minor) ______________________________Work phone: _________________ Home: ______________
Client's Sex: __ M __ F Age: ______ Marital Status: __ M __ Sin. __ Div. __ Sep. __ Wid.
Client's Race____________________ Client's Ethnicity/Culture_______________________________________
Is client a U.S. Citizen__Y __N If No, Explain status: ____
____
Prior Counseling: ____
____
____
Type of Counseling sought? For myself ___ Marital __ For My Child __ Premarital __ Other ____________
Description of reason client(s) seek counseling: ____
____
____
____
____
____

Will you be planning to pay through your insurance? _____ If so, please give us the information requested below, and, as a courtesy service, we'll verify coverage before your appointment and let you know your benefits. If you plan to pay without using insurance, please go now to the" 3rd Party" or "SELF PAY" section below, whichever applies. If you want to use your EAP program for payment,

please complete the "Insurance/EAP" Section. You'll then need to provide the requested info. for BOTH your EAP & your major medical insurance,

INSURANCE/ EAP INFORMATION:

Do you want to use: Insurance___? EAP___? BOTH___?
If you want to use both EAP and your major medical insurance and they are managed by 2 different insurance companies, ***please complete this form and return for <u>each</u> of the different insurance/EAP products you have.***
Do you have any secondary insurance? _____ If so, please complete this form and return for **<u>each</u>** insurance company you plan to use in your payment.

Name of the family member the insurance is under (Insured):_____________________________________
Insured's Member ID # _________________________ Insured's Employer____________________________
Insurance Company Name: ________________________ Date of Birth of Prospective Client: _______
Some insurance companies will give a separate phone # on their cards labeled: "Mental Health /Alcohol and Substance Abuse phone #". Please give us that # if your card has one: __________________________________
Customer Service Phone #: _________________________Provider Phone #_____________________________

Prospective Client's Insurance Information (If different from above)
Prospective Client's Name: ___________________________________ Client's DOB: __________________
Prospective Client's Member ID #_______________________________________
Relation to Insured: ____________________________

The cost of the initial session will be $175.00 and following sessions will cost $150.00. Please be advised that any deductible and/or co- payment will be due at each session. ***Payment accepted is cash and/or check only***. *No credit, debit or medical spending cards accepted.* As a courtesy to you we will file your insurance claim for you. **However, the client, not the insurance company, is ultimately responsible for full payment of all fees owed.**

Other 3rd Party Information: If someone other than an insurance company or the client has agreed to pay for the client's counseling, give us all contact information necessary to verify and bill for payment please.
____
____
____

SELF PAY:

If you plan to not use your insurance or other third party payers or do not have insurance, please be advised that the cost of the first session will be $175.00 and that following sessions will be charged $150.00 per forty- five minute session. Payment is due at each session. ***Payment forms accepted are cash or check. Credit, debit and/or medical spending account cards are not accepted.***

<u>OFFICE USE ONLY:</u> Download By: _________ Download Date__________ Date to Insur. Clerk______________
Sent to Insur. By: _________ Date Appt. made___________ Appt. Day, Date &Time__________________________________
Client will download intake forms ____ Client will come early___ Financial policy covered___ Directions given___
Business day Cx policy___ Custodial Parent Permission___ Notes: ____

<u>Insurance Staff Data Collected</u>: Spoke To: ______________________ Deductible? ___________ Amt. Met? ____________
Copay? ________ Max Sess #? _______ Precert Required? _____ 90791 approved? ____ 90847? ___ 90846? ___ 90837? ___
Precert #_________________________________ Total # of Sessions? ______
CPT Codes & Dates given as precert: ______________________________ Client notified______ Comments:_________________
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