Breakthru Counseling and Consulting, P. C.

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 on the BCC website 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 nighttime phone number. We look forward to serving you!

Information on person filling out this form:

Name: ___________________________ Home phone: __________________ Work phone: ______________________

Cell phone: ________________________ Email: ____

OK to leave a voicemail at: Home: Y N Work: Y N Cell: Y N Email ok to send? Y N

Who referred you to BreakThru?____

What is your relationship to the prospective Breakthru client?____

Prospective Client Information: *PLEASE PRINT CLEARLY* **DATE:__________________**

Prospective Client's Name: ____ Date of Birth: __________________

Address: ____

City: _____________________________ County: ____________________________ State: ____ Zip: ___________

Email: ____

Home phone: ____________________Cell phone: __________________ Work phone: ________________________

OK to leave a voicemail at: Home: Y N Work: Y N Cell: Y N Email ok to send? Y N

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:

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Prior Counseling: ____

____

Type of Counseling sought? For myself Marital For My Child Premarital Other ____________

Description of reason client(s) seek counseling: ____

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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 each of the different insurance/EAP products you have.*** Do you have any secondary insurance? _____ If so, please complete this form and return for **each** 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: ____

Fees: The cost of the initial session will be $200.00 and following sessions will cost $175.00 per 45-minute session. Please be advised that payment will be due when BCC services are rendered. *Payment for TeleMental Health sessions is by credit, debit, HSA or FSA cards only. Telehealth payment is via HIPAA compliant Ivy Pay. In person session payment can also be made by cash or check. Be advised there is a $50 return check fee.* As a courtesy to you we can 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.
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SELF PAY:

If you choose not use insurance or other third-party payers, please be advised that the cost of the first session will be $200.00 and that following sessions will be charged $175.00 per forty-five minute session. Payment is due when BCC services are rendered. *For TeleMental health sessions, only credit, debit, HSA or FSA cards are accepted utilizing HIPAA compliant Ivy Pay. For In person sessions, cash or check are also accepted. Be advised there is a $50 return check fee.*

OFFICE USE ONLY: 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: ____
Insurance Staff Data Collected: Spoke To: ______________________ Deductible? ___________ Amt. Met? ___________
Copay? ____ Max Sess #? ____ Precert Required? ____ 90791 approved? ____ 90847? ____ 90846? ____ 90837? ____
Precert #________________________________ Total # of Sessions? ______ Client notified______
Comments:____