



DR. TIMOTHY HECK: PATIENT INTAKE FORM – ADULT

Please print clearly – One person per section, please.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Male  Female

May we leave messages? Yes –  at home  at work  on cell phone

OR  No, please don't leave messages Employer: \_\_\_\_\_

Marital Status:  Single  Married  Other Referred by (name): \_\_\_\_\_

E-mail Address (optional) \_\_\_\_\_

Check one or both  Responsible party  Insurance Policy Holder

INSURANCE INFORMATION: (We will take a copy of your insurance card.)

Name of Insurance Company(ies) \_\_\_\_\_

- Referral Source
 Pastor / Minister / Church
 Doctor / Dentist Office
 Former FCA Client
 Family Member
 Friend
 Other \_\_\_\_\_

Please print clearly – One person per section, please.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Male  Female

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- Referral Source
 Pastor / Minister / Church
 Doctor / Dentist Office
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 Family Member
 Friend
 Other \_\_\_\_\_

NOTE: If insurance is filed, by either FCA or yourself, all regular rates must apply. If you are paying a reduced rate and try to file an insurance claim on your own, it constitutes insurance fraud and we will not release the information needed by the insurance company to process the claim.

Please read, date and sign back of page. Signature and date required.



**CONSENT FOR CLINICAL TREATMENT WITH DR. TIMOTHY HECK**

The staff of Family Counseling Associates (FCA) is committed to providing quality professional care to all of our clients. Your treatment information is handled with the utmost of care to ensure your privacy. Take a few moments to read the Privacy Information Policy (Health Insurance Portability & Accountability Act – HIPAA) you were given and sign this form for our records. FCA works as a group of providers and your confidentiality is extended to all therapists in the organization. If you are working with a Resident Therapist, that Counselor will review your case with a Licensed Supervisor on a regular basis for recommendations as part of the training provided Residents.

**Standard Fees for Services**

25 minute therapy session	\$ 65.00
50 minute therapy session	\$ 125.00
80 minute therapy session	\$ 165.00
110 minute therapy session	\$ 200.00
Consultations @ \$125.00/hour	

If you choose to use your health insurance coverage to help cover our services, please know that it is a contract between you and the insurance company. As a service to you, our office will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of those payments. In some cases insurance companies may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the *client, responsible party* and/or *insurance policy holder* is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The *client, responsible party* and/or *insurance policy holder* is responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 90 days are subject to collections. A 1½% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. All insurance benefits will be assigned to this clinic unless the account balance is paid in its entirety each session. Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Reimbursements to clients will be made only after all outstanding debt for the client and all family members is paid.

**PLEASE NOTE: Missed appointments or cancellations less than 24 hours prior to the appointment result in a charged fee of \$45.00. There is a \$20.00 fee for ALL RETURNED CHECKS. Checks that are dishonored by your bank twice must be paid immediately with cash or a credit card to avoid further legal action.**

Payment can be made by: **check, cash, VISA, MasterCard, American Express, or Discover.** Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

By signing below you are authorizing Family Counseling Associates to disclose case records to any listed third-party payer for the purpose of receiving payment reimbursement, including insurance carriers, Employee Assistance Program (EAP) providers, Membership Assistance Program (MAP) Coordinators with affiliated churches, and you are indicating your understanding of our confidentiality policy stated above with regard to HIPAA, Resident Therapists, and all FCA Staff who may need be involved in your case. In order for our FCA staff to contact any listed third-party payer, this consent must be signed by each client to enable FCA authorization to file any claim or necessary paperwork. This signed consent also authorizes FCA to provide counseling treatment or services.

I acknowledge that I have read Family Counseling Associates, Inc.'s Notice of Privacy Practices and will be given a copy of the same if I request it.

\_\_\_\_\_  
Signature (required)

\_\_\_\_\_  
Spouse's Signature (required, if participating in treatment)

\_\_\_\_\_  
Date (required)

\_\_\_\_\_  
Date (required)