Agape Counseling Associates, Inc
3806 Peachtree Avenue unit 210
Wilmington, N.C. 28403

phone 910-251-7789
fax 910-399-6598
e-mail: info@agape-counseling.org

Welcome to Agape…….a place where "RESTORATION TO HEALTH AND PEACE" begins.

We're very pleased that you've chosen to entrust us with your care.

In order to ensure that we have all the necessary information to contact you, please complete the following information. In the course of our work together, if any of this information changes, be sure to notify us.

PATIENT/CLIENT INFORMATION:

(Name) (Marital Status)

(Street Address)

(City) (State) (Zip)

Soc. Sec. # Birth Date (M / D / Y) (Spouse Date of Birth)

( ) - ( ) - x
Home Phone Bus. Phone

( ) - ( ) -
Cell Phone Fax

e-mail

In the event of an emergency, whom should we contact?

(Name) (Relationship)

(Street Address)

(City) (State) (Zip)

( ) - ( ) - x
Home Phone Bus. Phone

( ) - ( ) -
Cell Phone Fax

Email _____

How did you learn about this practice from: _____ yellow pages____ internet ____friend/family___ pastor/church

May we have your permission to contact you at home?____yes_____no work? _____yes_____no Cell?____yes____no (please check appropriate line)

Please Tell Us About Yourself:

Marital Status:

_____single _____separated……..how long_____
_____married _____divorced……..how long_____

Spouse's Name _____

Do you have any children/Step Children? List name, birthdates, sex, relationship, and whether they live at home.

Name	Birthdate	Sex	Relationship	At home?
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Place of employment: _____

Occupation: _____

Please fill out the following information as it applies to you.

A. Counseling Information

Have been through counseling before? _____yes _____no
If yes, when? _____
Name of Therapist _____For what reason? _____
Are you, currently seeing a psychiatrist, psychologist, or another therapist?
Yes_____ No_____
If yes, please give us their name:_____
For what purpose? _____
Do we have your permission to contact this clinician ? If so, please initial below….

Initials _____

B. Crisis Information

Are you having any current suicidal thoughts or feelings? Yes_____ No_____
If yes, please explain_____
_____

Are you having any anger-control problems, or feelings? Yes _____ No_____
If yes, please explain _____
_____

C. Medical Information:

Primary Care Physician _____
Address:_____
_____
Phone# _____
Do we have your permission to contact this Primary Physician for treatment purposes?
Yes _____ No _____

Are you presently taking any medications? Yes_____ No _____

If so, please list medications and reasons for taking them
_____ for _____

_____ for _____
_____ for _____

Any problems with:

_____Sleeping?
_____Eating?
_____Chronic Pain?
_____Recent weight changes?

Any other medical concerns that you would like for us to know about?

_____
_____

D. Common Problem/Symptom Checklist:

0=none 1=mild 2=moderate 3=severe

____marriage	____ divorce/separation	____ God/Faith
____child custody	____ substance abuse	____ Church/Ministry
____singleness	____ disability	____ grief/loss
____past hurts	____ sexual issues	____ work/career
____depression	____ codependency	____ addiction to pornography
____school	____ fear/anxiety	____ intimacy
____parents	____ loneliness	____ communication
____self-esteem	____ in-laws	____ aging/dependency
____stress	____ mood swings	____ weight control
____food/nutrition		

other_____

Payment Information: My signature below indicates that I am the responsible party for payment for all sessions with this practice.

_____ Date _____
(Patient/Guardian signature)

Financial Responsibility information if different from person listed above:

_____
(name of person responsible for payment)

<u>Consent for Exchange of Information</u>

I _____ give permission for Agape counseling Associates, Inc to (exchange, release, obtain) billing, appointments, and/or medication information with the following:

Please Print:	Your Initials:
_____	_____
_____	_____
_____	_____

I understand that this practice has multiple providers. I authorize all staff/associates of Agape Counseling Associates, Inc to exchange, obtain and release information for the purpose of coordinating my care.
Initials _____

I understand that this consent is valid for 1 year unless otherwise stated or that I resend with written notice
Initials _____

Office Policies

Please read the following polices and sign. With your signature you are agreeing to the policies and take responsibility of being informed of the policies.

Copay and Deductibles: With a few exceptions, patients usually have a fee associated with their insurance that is due at the time of service. Please review your policy to fully understand your responsibility according to your insurance contract.

- Copays, co-insurance, and deductibles are due and expected at each appointment prior to being seen.
- If the patient is unaware of their benefits, the full fee will be taken to cover the visit until billing receives a response from your insurance. If this results in a credit, that amount will be applied to your account.
- Please call our office with your insurance information PRIOR to your appointment. If a patient arrives for an appointment without insurance information, that visit will be assessed as a self pay appointment until insurance information can be verified and applied for additional visits.
- Patient balances are expected to be paid along with copay amounts where applicable.
- IF the patient's insurance changes, it is advised that you call the office prior to your appointment as not all providers are in network with all insurance carriers.
- The office does not process with Medicaid and Medicare. We can provide a "super bill" that you can submit to Medicaid or Medicare.

Missed Appointment Charge: If a patient fails to show for an appointment or if the appointment is canceled less than 24 hours prior to the appointment time, (including after hour messages left) a 50.00 broken appointment fee will be accessed to the patient and must be settled prior to the next appointment. Continued broken appointments may result in the full fee. We have an office voicemail set up for the weekends for patients to cancel appointments with their specific provider for appointments on Monday. Emergencies are handled on a case by case basis are left up to the provider for the final decision. As a courtesy, we will attempt to give an appointment reminder call, but it is still the patient's responsibility to remember their appointment times. This does not waive the missed appointment fee. Please inform the office if you are going to be late for your appointment time. You may email your provider, or call the office voicemail if needed. In some instances, a provider may have to reschedule the appointment based on scheduling and calendar demand as a session hour has been reserved for you.

Requests for Notes and other Correspondence: If a patient requests records for notes to be sent to another entity (other than a healthcare provider of the patient), there is a fee per page and the patient must sign a release in the office. Generally, we try to accommodate all requests within 3 to 4 days if all paperwork has been signed and released.

Consent for Treatment:

I understand that I have chosen to be treated by _____ at Agape Counseling Associates, Inc. My signature below is my indication that I have read and agree to the Office Policy for Agape Counseling Associates, Inc. understanding that my full participation with my counselor as well as abiding by all office policies means that I have made a significant investment in my personal mental health and will work hard with my counselor to meet treatment objectives.

_____ _____

Patient/Parent or Guardian/ Legal Representative Date