Jude Thaddeus Currier, LICSW

ParentCoach Family Counseling, LLC
199 State Route 101, Unit 973
Amherst, NH 03031

PATIENT INFORMATION

NAME: _____ **DOB:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **OK TO LEAVE MSG? Yes No**

CELL PHONE: _____ **OK TO LEAVE MSG? Yes No**

EMAIL: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ **PHONE:** _____

INSURANCE INFORMATION

Please forward a clear image of the front and back of your insurance card to: **melody@parentcoach.org**

Insurance Authorization and Assignment:
I hereby authorize the Provider of Services to furnish this information to insurance carriers concerning my condition and treatment. I hereby assign the provider all payment for medical services rendered to my dependents or myself. **I understand that I am responsible any amount not covered by insurance. Initial:_____**

Copayments and deductibles are due at the time of service.

Signature: _____ Date: _____

Phone: (603) 595-9355
Fax: (866) 579-5833
E-Mail: Jude@Parentcoach.org
www.parentcoach.org

Jude Thaddeus Currier, LICSW

ParentCoach Family Counseling, LLC
199 State Route 101, Unit 973
Amherst, NH 03031

Billing Policies

We are happy to bill your health insurance for you as part of your treatment. A few guidelines apply here:

- Each patient is required to fill out an electronic payment authorization form. This provides us with an alternate way to bill for missed appointments or insurance co-payments and deductibles. If you choose not to fill out this form, we will require that you fund a retainer in the amount of One-Hundred and Fifty Dollars ($150.00). **Initial _____**

- Co-payments and deductibles are due at the time of the session. If you choose to pay by credit or debit card, there will be a 3% surcharge. **Initial _____**

- Please be aware that time spent in records review and / or consultation with other providers or collateral contacts is not reimbursable by insurance and will be billed directly to you. You will not be billed for interaction for the purposes of scheduling or other administrative issues.
Initial _____

- If the client is a minor, the presenting parent is responsible for any payments due at the time of the session. This supersedes any and all court orders. **Initial_____**

Missed Appointments

Insurances do not reimburse for late cancellations or missed appointments. Because Jude is a fee for service clinician, missed appointments amount to lost revenue. Therefore, if a patient misses an appointment, or does not give the office **at least 48 hours' notice** for cancellation or rescheduling, you will be billed the no-show fee of One-Hundred and Fifty Dollars ($150.00). If your insurance (i.e. Medicaid) does not allow for billing of missed appointments, there is a strict **no-show limit of two sessions**. **Initial _____**

Certainly, there are exceptions. If you are ill (or your children are ill and need your care) no charge will be made for a late cancellation under these circumstances. Exceptions will **not be made for child care issues or work conflicts if 48-hours' notice** is not given. Please understand that I cannot be flexible on this policy. **Initial _____**

My signature below indicates that I have read and understand the above policy.

Signature: _____

Print Name: _____ Date: _____

Phone: (603) 595-9355
Fax: (866) 579-5833
E-Mail: Jude@Parentcoach.org
www.parentcoach.org

Jude Thaddeus Currier, LICSW

ParentCoach Family Counseling, LLC
199 State Route 101, Unit 973
Amherst, NH 03031

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychotherapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being abused, I am required to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Print Name: _____

Signature: _____

Signature of Parent (if minor): _____

Date: _____

Phone: (603) 595-9355
Fax: (866) 579-5833
E-Mail: Jude@Parentcoach.org
www.parentcoach.org

Jude Thaddeus Currier, LICSW

ParentCoach Family Counseling, LLC
199 State Route 101, Unit 973
Amherst, NH 03031

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, Discover and American Express. Service fees will be deducted from the designated account at the time services are rendered.

Client Name: _____ Date of Birth: _____

Cardholder Information:

Please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).

_____ _____
Cardholder Signature Date

Credit/Debit Card Information:

Please provide your payment information below.

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: _____

CVV: _____ Expiration Date: _____

Please initial one of the below lines:

- This is a flexible spending or health savings account. I am aware that they may not cover some fees such as card processing, administrative time and missed appointments. Initial _____
- This is a personal credit or debit card. Initial _____

Phone: (603) 595-9355
Fax: (866) 579-5833
E-Mail: Jude@Parentcoach.org
www.parentcoach.org