Fountains Family Counseling
10293 E 126th St
(Inside Hamilton Hills Church)
Fishers, IN 46038
(317) 721-4801

Client Yearly Updated Information Form

Office Use Only
Dt: ___________
Dx: ___________
Rf: ___________

Full Name: ____Date of Birth: ______________________

Address Changes? YES NO

If yes: ____

Phone number or email changes? YES NO

If yes: ____

Please list current medications: ____

Changes to Insurance? YES NO

If yes:

Using Insurance Y N Which company? ______________________________________

Policy Holder ____

Birthday of Policy Holder ___________

Member Number ______________________________ Group Number ____________________

Plan ID (if different than Member Number) ____

Co-Pay Amount (if applicable) ____

CC/HAS/FSA card number to keep on file:

****No charges will be made to this card until we hear from insurance and you are contacted by FFC****

____ ______________________

Authorized Signature of Card Holder Date

Printed Name on Card: ____

Patient's Name: ____

Card Type: ( ) American Express ( ) Visa ( ) Mastercard ( ) Discover ( ) FSA or HAS

Card Number: ____

Expiration Date: ________________________ Security Code: __________________

Zip Code: _________________________ Effective Start Date: __________________

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New Patient Information Form (cont.)
Informed Consent for Therapy Treatment

PLEASE READ CAREFULLY AND SIGN BELOW

A. I am giving my expressed permission for Amy Brant to provide psychological assessment, diagnosis, and treatment in order to assist me in reaching my intrapersonal and/or interpersonal goals.
B. As a client under the care of Amy Brant, I understand that no guarantees are being offered for the outcome of my therapy with the exception that my therapist will make every effort to understand my problem(s) and incorporate well-established, conventional psychological techniques to help ameliorate personal problems that are causing me and/or my family to experience hardship.
C. I further understand that, in relationship counseling, my therapist will be fair to both parties and does not take sides in therapy, but rather is on the side of being healthy in the relationship.
D. If the patient is a minor, I, as the parent, custodial parent, or guardian, give consent for treatment to said minor and will respect the confidential nature of the relationship between my child and her/his counselor.
E. In regards to risk of hurting myself or others, I agree to notify Amy Brant immediately and provide her with ample opportunity to help before taking any actions that may result in harm to myself or others.
F. Payment for Services: I understand that Amy Brant's hourly fee of $105 for individual, relationship and family counseling services as well as consultation services is to be paid in full *at the time of service* and that I authorize Amy Brant to charge my credit card for services rendered if other payment options are not present. If I use insurance, FFC will file claims and I agree to make payments of $105/hr until deductible is met. I also agree to pay and co-pay fees specific to my insurance plan. Insurance companies will be billed at the rate of $135/hr as per individual agreements with all insurance companies. Returned checks are $25 fee.
G. Court Fees: I understand that if Amy is required to testify in court or to type up court-subpeonaed notes for a case, the rate is $105/hr to be billed in quarter time sessions.
H. Phone Consultations: I understand that there is no charge for brief administrative phone calls under 5 minutes. If a call results in a consultation for 5 minutes or longer, I will be charged for the entire duration of the phone consultation at Amy Brant's pro-rated hourly fee.
I. I understand that my personal information and my status as a patient will be held in the strictest confidence unless I give my expressed permission in advance. *Exceptions*: Court orders, and being a danger to self or others. In case of reported abuse/neglect of a dependent, appropriate Protective Services must be notified. Failure to do so may result in a Class B misdemeanor.
J. Cancellation Policy: As a courtesy to others, I understand that I am responsible for maintaining my appointments and my signature below indicates that I will provide Amy Brant with NO LESS THAN 24 HOURS notification when changing or canceling my appointment or a full session fee will be charged. If I am going to be more than 20 minutes late to an appointment, the appointment will need to be rescheduled so that I can get optimal therapy time.
K. Voicemail: I understand that Amy Brant will return my voicemail messages as soon as is possible for her and that if I have a psychological emergency that cannot wait for her returned call, I will contact my local emergency room for consultation in the interim.
L. E-mail: I understand that Amy Brant cannot guarantee my confidentiality if I contact her via e-mail and that she will not engage in e-mail therapy.
M. I understand that Amy has a limited schedule and only works the following hours and times: MTThF 10 am-2 pm, with the exception of holidays. Appointments will be extremely limited in the months of June and July or during school scheduled vacations. I understand that I may not get in for an appointment for 2-4 weeks during June and July and for up to 2 weeks in December. June and July hours are as follows: TThF 7 am-11 am.
N. I understand that Fountains Family Counseling, LLC resides in a communal office space, and therefore agree to keep noise and movement to a minimum while in the waiting area as not to disrupt other businesses.

By placing my signature below, I attest that I have read this document; I am consenting to treatment and agreeing to abide by the practice policies delineated by Fountains Family Counseling; and I have received a paper copy of Fountain's Family Counseling Notice of Privacy Practices.

Signature: ____ Date: ____________________
[Adult and/or Party Responsible for Payment]

Print Name: ____