NEW PERSPECTIVES CENTER

for Counseling and Therapy

1675 Winter St. NE
(503) 316-6770

Individual Information **Date** _____

Legal Name: _____
Preferred Name:_____**Maiden Name:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:**_____ **County:** _____

Physical Address (if different than mailing address): _____
City: _____ **State:** _____ **Zip:**_____ **County:** _____

Phone: (____)_____ **Work Phone:** (____)_____ **Cell:** (____)_____

Date of Birth: ____/____/____ **Social Security Number** _____

Email Address:_____

Emergency Contact: _____ **Phone Number:** (____)_____

Mailing Address: _____

Referred by: _____

Primary Care Physician: _____ **Phone:** (____)_____
Address: _____
Pharmacy:_____ **Address:**_____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Living as Married

Gender: □ Male □ Female □ Other **Legal Gender:** □ Male □ Female □ Other

Employer or School: _____ **Employed:** □ Full-Time □ Part-Time
Highest Grade Completed: _____ □ Student □ Non-Employed
Occupation: _____
Parent's/Partner's Name: _____
Parent's/Partner's Employer: _____ Work Phone: (____)_____

Legal Guardian (if applicable) Name/Agency: _____ Phone: (____)_____
Address: _____

Is the individual covered by insurance? □ Yes – Go to section II □ No – Go to section V

Section II – Insured Information _____

Individual Relationship to Insured: □ Self □ Spouse □ Child □ Other

If "Individual Relationship to Insured" is other than "Self" please complete the section below. If individual (the one becoming a client with NPC) is the one insured, go directly to Section III.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Work Phone: (_____) _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Marital Status: □ Single □ Married □ Other Gender: □ Male □ Female

Employer or School: _____

□ Employed □ Full-Time Student □ Part-Time Student

Section III – Insurance Policy Information _____

□ Medicare □ Oregon Health Plan □ Private Group Health Plan □ Other

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Plan Name: _____

Policy Number: _____ Group Number: _____

Is the Individual covered by more than one insurance? □ Yes – **Please complete Section IV**

□ No – Please return this form to the receptionist

Section IV – Secondary Insurance Policy Information _____

□ Medicare □ Oregon Health Plan □ Private Group Health Plan □ Other

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Plan Name: _____

Policy Number: _____ Group Number: _____

Section V – Billing Information _____

Who is responsible for charges for this Individual?
□ Individual (client) – Please return this form to the receptionist
□ Other-Please complete the information below:
(please note that whomever signs the Individual Client Agreement will also be held responsible for all charges)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Work Phone: (_____) _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Employer: _____

Marital Status: □ Single □ Married □ Other Gender: □ Male □ Female

Relationship to Individual: _____

NEW PERSPECTIVES CENTER
for Counseling and Therapy

1675 Winter St. NE
(503) 316-6770

CLIENT AGREEMENT

In an effort to keep mental health costs down while maintaining a high level of professional care, we have established the following payment policy for our clients. Our primary responsibility is to help our clients experience good health and we wish to spend our time and energy toward that end. Therefore, we would like to take the time now to fully explain our policy to you in order to avoid any misunderstanding in the future.

- **All fees are due and payable at the time of your visit.**

- We do accept insurance as full or partial payment of the fee and will be happy to bill the insurance carrier for you. Even though you have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. **We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier.** You are responsible for payment of your account within the usual limits of our credit policy. After 90 days, delinquent accounts may be assigned for collection assistance. If this becomes necessary, a $25 service charge will be added to the account to cover the costs of the additional handling required. This will ensure that our clients who keep their accounts current will not be penalized to cover the costs incurred by those who don't pay.

- **We require a 24-hour notice of cancellation of your appointment; otherwise you will be charged $35.00 for the session.** A missed appointment is wasted time for all involved, and the 24-hour notice gives us an opportunity to reschedule that time with someone else that needs to be seen. We have an answering machine that operates 24 hours a day, seven days a week so that you can leave a message anytime, nights and weekends included.

- **Telephone calls other than to make or change appointments will be billed at the regular rate.**

- We may need to bill you if we are required to make outside consultations that are not covered by insurance (i.e. insurance reviews, school counselors, physicians, court, attorneys, etc.).

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult with us if you have any questions regarding our services and fees. It is not our intention to cause you undue hardship. However, we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read this credit policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs, attorneys' fees, and all court costs.

Client Name: _____

Client/Parent/Guardian Signature: _____ **Date:** _____