



THE CENTER

For Counseling and Wellness

www.thecenter4counseling.com

The Center for Counseling & Wellness

Client Intake Signature Form and Virtual Care Emergency Contact Information

Client Legal Name _____

Client Preferred Name _____

My signature below confirms that I have received, reviewed, and/or completed a copy of:

- **The Center for Counseling & Wellness' Disclosure Statement with Informed Consent to Participate in Clinical Counseling, HIPAA Rules, and Virtual Care Disclosure**
- **Notice of Privacy Practices for The Center for Counseling & Wellness**
- **The Center For Counseling & Wellness Biopsychosocial History Intake Form**
- **My counselor's personal Professional Disclosure Statement**

and have had an opportunity to discuss any questions I have about this information. I acknowledge that a copy of these documents has been made available to me at no charge and that they are available on our website at thecenter4counseling.com.

Client's Signature (Parent/Guardian if client is a minor) Date

In emergency situations for Virtual Care, contact: _____ at _____
Local Police Department Phone #

For disruption of service for Virtual Care, contact: _____ at _____
Land line or other cell phone Phone#

My Client Support Person for Virtual Care is: _____ at _____
Name Phone#

My email address is: _____

Updated 10/14/2022

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach
3505 Main Street, Loris | 602 Main Street, Conway
Phone (843) 663-0770 | Fax (843) 663-0772 | Email: admin@thecenter4counseling



CLIENT LEGAL NAME AS SHOWN ON INSURANCE CARD: _____

CLIENT PREFERRED NAME: _____ CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT

The Center for Counseling & Wellness

____ INSURANCE (Fill out this section if you are using insurance to pay for treatment)

PRIMARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

____ PRIVATE OR THIRD-PARTY PAYMENT (Fill out this section if insurance is not applicable)

Sliding Fee Scale: Agreed Amount: _____ Staff Initials: _____	Third Party Payor: Name: _____ Address: _____ Contact Number: _____
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AUTHORIZATION AND RELEASE

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I understand I am personally responsible for payment of all insurance co-pays and deductibles regardless of any insurance payments made to The Center for Counseling & Wellness (The Center). I authorize The Center to release all information necessary to process any insurance claims or third-party payment. I authorize payment of insurance benefits directly to The Center. I understand the **Late Cancellation fee of \$50** is not covered by insurance and is accordingly my responsibility (*does not apply to Medicaid clients*). **There will be a \$25 fee for all returned checks.** I understand if I am a self-pay client, I have the right to a good faith estimate of the cost of each visit and the agreed amount above is such an estimate. I further understand my account needs to remain current to continue in the counseling process.

Client Signature/Parent or Guardian Signature if Minor

Date



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Credit Card Authorization Form

Credit Card Information Card Type: MasterCard VISA Discover AMEX

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder Billing Address & Zip Code:

I, _____ (client legal name), authorize *The Center for Counseling & Wellness*, to charge my credit card listed above for counseling services. I understand that my information will be saved to file for future transactions on my account.

I agree to pay \$_____ for each individual session.

Signature of Client/Representative _____ Date _____

Client Printed Name _____ Date of Birth _____

Relationship to Client _____

****ALL CREDIT CARDS WILL BE SUBJECT TO A 3.5% PROCESSING FEE EFFECTIVE 1/1/2023****

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