Hurley Counseling, LLC
CHILDREN | ADOLESCENTS | ADULTS

Welcome to Hurley Counseling LLC:

We appreciate you choosing Hurley Counseling as your service provider. We know you have many options for your counseling needs. We have Licensed Marriage and Family Therapists, Licensed Professional Counselors, and a Psychologist to address a variety of needs and provide a variety of evidence based solutions. With a total of 10 therapists and offices in Mobile and Daphne, we are committed to providing the best possible care in Mobile and Baldwin Counties.

For your convenience, this packet includes: the intake form, billing information and policies, teletherapy consent form and policies, privacy policies, cancellation/no show policies, coordination of care form and policies, and the release of information form. Please read over, complete, scan and email them to Office@HurleyCounselingLLC.com prior to your first session.

One of the benefits of being treated at Hurley Counseling is that our therapists often work together as a team to review cases. If you are uncomfortable with this approach, please notify us of your concerns in writing or speak to your therapist. We are honored by your faith in us to provide counseling services to you and your family. If you have any questions, please call or text the office at 251.222.8880 or email us at Office@HurleyCounselingLLC.com.

Sincerely,

Leigh R. Hurley, LPC
Executive Director

HurleyCounseling, LLC
CHILDREN | ADOLESCENTS | ADULTS

Services/Fees

Below are the basic services and fees. These are subject to change depending on your insurance.

Individual, Couples, and Family Counseling

- 60-minute session with a Master's Level (Associate License) Therapist……..……...$80 - $105
- 60-minute session with a Master's Level (Licensed) Therapist……...$136 - $190
- 60-minute session with a Licensed Psychologist…….…….. $168 - $200

Testing and Evaluation*

- Psychological/psychoeducational……$1,500 - $2,500
  (Fees are contingent upon the diagnostic question and appropriate tests)

*Insurance will not cover these services.

1327 Spring Hill Ave. Mobile, AL 36604
101B Villa Dr., Room 209, Daphne, AL 36526
office@hurleycounselingllc.com | 251.222.8880 | www.Hurley-Counseling.com

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Adult Intake Paperwork

General Info

Name:_____ Date of Birth:___/___/_____Age:_____

Preferred Name:_____ Gender:_____Preferred Pronouns:_____

Address:_____ City:_____ State:_____ Zip Code: _____

Can we send mail here? ☐ Yes ☐ No

Main Phone Number:_____ Can we leave a message? ☐ Voice ☐ Text ☐ None

Other Phone Number:_____ Can we leave a message? ☐ Voice ☐ Text ☐ None

Email:_____Contact you here? ☐ Yes ☐ No

Appointment Reminders sent to: ☐ text ☐ email ☐ none

How did you hear about Hurley Counseling, LLC?_____

If this form is completed by an informant, what is your relationship with the individual?_____
If so, in a typical week, approximately how much time do you spend with the individual? _____hours/week

Employer Info

☐ I am employed ☐ I am self-employed ☐ I am unemployed ☐ I am retired

Company:_____Occupation:_____ ☐ Full-time ☐ Part-time

Position: _____ How long have you been at this company? _____

Highest level of education completed:_____

Currently in school? ☐ Yes ☐ No. If yes, what level?_____Degree pursuing:_____

Emergency Contact Info

Name:_____Phone:_____Relationship:_____

Relational Information

Current marital status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
For how long?_____

Number of previous marriages for you?_____For your partner/spouse?_____

Partner/Spouse's name:_____ Age:_____

Is your partner/spouse supportive of you seeking counseling? ☐ Yes ☐ No ☐ Unsure ☐ They do not know.

What words would you use to describe your partner?_____

How would your partner describe you? _____

With whom do you currently live? (*Check all that apply)* ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s)
☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

List your children (including step, adopted, foster) below:

Name	Age	Indicate psychiatric, substance use, or concerning behaviors.

Relational Information cont.

Have you ever placed a child for adoption? ☐ Yes ☐ No. If yes, when?_____

Have you or someone you have been in a relationship with ever had a miscarriage or medical abortion?
☐ Yes ☐ No. If yes, when?_____

List family members who had/have a significant (positive or negative) effect upon your life:

Name	Age	Relationship to you / side of the family.	Indicate psychiatric, substance use, or concerning behaviors.

Mental Health History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists, psychiatrists, or programs:

Name of therapist, psychiatrist, or program	Major issue(s) addressed	Dates

Medical History

List any medical conditions, illnesses, treatments, or surgeries:_____

_____

Your height:_____ Your weight:_____.

How has your weight changed in the last 2-3 months? ☐ little or no change ☐ up_____lbs. ☐ down_____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed.

Name of Medication	Dose	Reason for taking medication

Primary Physician:_____Phone:_____

Have you experienced suicidal thoughts? ☐ Yes, current ☐ Yes, past ☐ No.

Have you ever attempted suicide? ☐ Yes ☐ No. If yes, when and how?_____

Has a friend or family member ever committed or attempted suicide? ☐ Yes ☐ No.
If yes, when and who?_____

Are you presently experiencing any thoughts of harming another person? ☐ Yes ☐ No.

Medical History cont.

Have you experienced sexual assault and/or sexual, verbal, emotional, or physical abuse? ☐ Yes ☐ No.
If yes, describe._____

Have you ever experienced or witnessed a life-threatening situation? ☐ Yes. ☐ No. If yes, describe._____

Current Issues

Instructions: The questions below ask about things that might have bothered you. For each question, check the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the **past TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	2. Feeling down, depressed, or hopeless?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
III.	4. Sleeping less than usual, but still have a lot of energy?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	5. Starting lots of more projects than usual or doing more risky things than usual?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	7. Feeling panic or being frightened?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	8. Avoiding situations that make you anxious?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
V.	9. Unexplained aches/pains (e.g., head, back, joints, abdomen, legs)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	10. Feeling that your illnesses are not being taken seriously enough?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
VI.	11. Thoughts of actually hurting yourself?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
XII.	19. Not knowing who you really are or what you want out of life?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	20. Not feeling close to other people or enjoying your relationships with them?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	22. Smoking cigarettes, a cigar, pipe, or using snuff/chewing tobacco?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	

Current Issues cont.

How well you are doing on your job:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not working	Cannot function		Serious problems		Moderate problems		Mild problems		No problems

How well you are doing in your marital/significant other relationship:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot function		Serious problems		Moderate problems		Mild problems		No problems

How well you are doing in your family relationships:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot function		Serious problems		Moderate problems		Mild problems		No problems

How well you are doing in relationships with people outside your family:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot function		Serious problems		Moderate problems		Mild problems		No problems

Please rate your current physical health:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very poor					Moderate				Excellent

Please rate your general happiness and well-being:

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very poor					Moderate				Excellent

Please check the box on the scale below to indicate how distressing your problem(s) are to you.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	☐10
Minimally Distressing					Moderately Distressing					Extremely Distressing

Please describe why you are coming to counseling now (*i.e., What are your issues, problems?*):_____

_____

_____

What do you hope to gain or change by coming for counseling?_____

_____

Are there any other things that can be helpful for us to know about you?_____

_____

Additional Info

Are you involved in any legal proceedings? ☐ Yes ☐ No. If yes, describe._____

_____

Are you required by a court of law to receive counseling as a part of a legal proceeding? ☐ Yes ☐ No

Have you obtained services from Hurley Counseling, LLC before? ☐ Yes ☐ No. If yes, when?_____

HurleyCounseling, LLC
CHILDREN | ADOLESCENTS | ADULTS

Notice of Privacy Practices for Protected Health Information

This notice describes how your therapeutic and/or mental health information may be used and disclosed and how you can get access to this information. Please review it carefully.

The law (45 CFR Part 164) requires that medical information (which includes mental health) is kept private. It also requires that you are given this notice of what this office does with your medical information about you. Hurley Counseling, LLC reserves the right to change this notice and policy but will notify you in the case it does.

How your medical information may be used:

In general, your medical information is used in two ways:

1. To provide patient care to you. Your medical information may be used by doctors, nurses and other professionals who are treating you. For example, your medical information is used to help your care givers find out your problems and to decide the best way to treat you.

2. To obtain payment. Your information may be used to prepare your bill and process your payment from you or other person who is responsible for payment.

How your information may be disclosed:

In general, beyond the above use of your medical information, your records are only given with your written authorization to those whom you ask us.

There are exceptions:

1. In the case that there is evidence of abuse, neglect, or domestic violence in which by law a report must be filed with the appropriate law enforcement agency.

2. Medical information must be revealed if ordered by a judge because of a legal issue or if required by law. One example of this occurs would be if you were to bring suit against someone for emotional damages. In this case, usually the defense attorney has a legal right to review your medical records.

3. If a person was to have an uncontrollable urge and/or plan to kill someone, the prudent doctor would hospitalize the patient to be sure everyone was safe. In these cases, the doctor is required to warn the person who is the target of such intention.

4. Medical information may be revealed about persons who have died to coroners, medical examiners, and funeral directors as allowed by law.

5. Hurley Counseling, LLC may be required to disclose your medical information for certain specialized governmental functions as allowed by law. Such functions include:
    a. Military and veterans activities
    b. National security and intelligence activities
    c. Protective services to the President and others
    d. Correctional institutions and other law enforcement custodial agencies.

Family and Friends:

1. If family members call with information that may be important to your care, your health care provider may take the call and listen to the information. He/she will not disclose any information obtained during appointments without your written permission. They will then speak to you about the call at your next appointment, or sooner, if necessary.

2. It may be beneficial to foster supportive family members and friends. **With your permission**, your clinician at Hurley Counseling, LLC might help facilitate healthy relationships among friends and family.

Other rights:

1. In general, the above is the usual, customary way the staff at Hurley Counseling, LLC handles your medical information. However, you have the right to request that your health care provider to treat your medical information in a special way, different from what is normally done. Your therapist will use their clinical judgement to take into account your wishes, relevant laws, and the best interest of all parties involved. If we do agree with you, we have to follow your wishes until we tell you that we will no longer do so.

2. You have the right to tell us how you want the information sent to you. For example, you might want us to call you only at work or only at home, or to use texts or email messages. We will make every effort to comply with your wishes within our means.

Acknowledgement of receipt of Notice or Privacy Practices

I,_____, acknowledge that I have received a copy of the Notice of Privacy Practice of Hurley Counseling, LLC.

_____

Signature of Patient, Parent, Guardian, or Other Authorized Representative Date

Consent to Teletherapy Services

Teletherapy services are a form of psychological therapy service which is provided via secure internet technology at a prearranged time. Specifically, Teletherapy involves a therapist and a client interfacing via their computers or smart devices using high encryption telemedicine software over the internet. It has the same purpose or intention as face-to-face psychotherapy treatment sessions, though it is not a universal substitute for this type of service. The Teletherapy services provided by Hurley Counseling, LLC therapists occur in the state of Alabama (USA) and are thus governed by the laws of this state.

Client Requirements

Clients who are at risk of harm to themselves or others are not suitable for Teletherapy services. If you become suicidal or homicidal during treatment, please inform your therapist and we will discuss options that will be better suited for you.

Technology Requirements

You will need the following in order to engage in Teletherapy sessions:

- A computer or smart device with a webcam and audio ability
- A phone (in case of technical difficulties)
- A stable internet connection
- In addition, in order to avoid being overheard by anyone in your vicinity during Teletherapy, it is important that you place yourself in a private room. It is your responsibility to create a comfortable environment and safe environment on your end, while it is the responsibility of the therapist to create the same on his/her end.

Rights and Risks of Teletherapy Services

- You have the right to withdraw from Teletherapy service at any time. If you choose not to utilize Teletherapy services it will not affect your right to further treatment, and you can continue face-to- face therapy with your current therapist.
- Teletherapy services may not be an appropriate treatment modality for every client and, at times, may even be counter-productive. Your therapist reserves the right as your therapist to determine if Teletherapy sessions are not in your best interest. If this is determined, your therapist will continue face- to-face services with you or provide referral information if necessary.
- The same laws and policies which are stated in the MANDATORY DISCLOSURE & CONSENT FOR TREATMENT form in regards to regular psychotherapy, confidentiality, exceptions of confidentiality, etc. - also apply to Teletherapy services.
- It is possible that a Teletherapy session may be disrupted or distorted by unforeseen technical issues. If you are disconnected during a session due to a technological issue, the therapist will reinitiate the session. If unable to reconnect the session, he/she will call you via the phone number you have provided on the Initial Intake Form.
- The CANCELATION & NO SHOW POLICY remains the same for Teletherapy services. If you are unable to connect to a Teletherapy appointment at the allotted time, please call or email your therapist directly 24 hours prior to the appointment. Otherwise, your session will be considered a “No Show.” In circumstances where a connection cannot be made due to technical difficulties in the time allotted for a session (and you contacted your therapist for assistance), you will not be charged a fee.

- Teletherapy is NOT designed for and will not be used as an emergency service. If you are in crisis or in an emergency, you should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in your immediate area. By signing this document, you understand that emergency situations include if you have thoughts about hurting or killing yourself or another person, have hallucinations (see or hear things others don't, or have delusions or beliefs others may consider unrealistic), if you am in a life threatening or emergency situation of any kind, are having uncontrollable emotional reactions, or if you are dysfunctional due to abusing alcohol or drugs. By signing this document, you acknowledge you have been told that if you feel suicidal, you are to call 9-1-1 or the National Suicide Prevention Hotline toll free at 1- 800-273-8255.

- Although all efforts are made to ensure high encryption and security in technology used, there is always a risk that transmission may be breached or accessed by unauthorized users.

- You are responsible for making payments for Teletherapy services that you participate in.

- By signing below, you agree that you have read, understand, and agreed to the above TELETHERAPY SERVICES AGREEMENT & INFORMED CONSENT. In addition, you will assume all of the foregoing risks and accept personal responsibility for confidentiality issues regarding Teletherapy services and recuse your therapist and Aspen Counseling Group from any liability if confidentiality is breached when these communications occur.

Signature of Patient, Parent, Guardian, or Other Authorized Representative Date

HurleyCounseling,LLC
CHILDREN | ADOLESCENTS | ADULTS

Coordination of Care
Authorization to Release and/or Exchange Information

Patient's Name: _____ **DOB:** _____

Communication between your therapist and your primary care physician (PCP), other behavioral health providers and/or facilities, your insurance company, a school professional, attorney, and/or personal contacts is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with others. This information will not be released without your signed authorization. This PHI may include mental health diagnosis, treatment plan, summary of progress, psychological evaluation report, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize Hurley Counseling, LLC to release verbally or in writing information regarding any medical, mental health diagnosis or treatments recommended or rendered to the above identified patient. I understand these records are protected by federal and state laws governing confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in one (1) year from the date of my signature below unless otherwise stated herein.**

Hurley Counseling, LLC is authorized to release protected health information related to the evaluation and treatment of the patient/member indicated at the top of this form with the following:

Primary Care Physician: _____ Phone: _____
Address: _____ Email: _____

Mental Health Provider: _____ Phone: _____
Address: _____ Email: _____

Other Specialist: _____
Name: _____ Phone: _____
Address: _____ Email: _____

Personal Contact (Family Member or Friend)
Name: _____ Relationship to Patient: _____
Phone: _____ Email: _____

_____
Signature of Patient, Parent, Guardian, or Authorized Representative Date

HurleyCounseling, LLC
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Client Cancellation and No Show Agreement

Effective July 26, 2021, Hurley Counseling will enforce a new Cancellation and No Show Policy.

Our goal at Hurley Counseling is to provide quality care in a timely manner. In order to ensure excellent service, we have implemented a new appointment Cancellation and No Show Policy. This policy enables us to better utilize available appointments for both new and existing clients.

Please note that once you have booked an appointment with us, it means that we have reserved time in our schedule exclusively for you. Each time a client misses an appointment without providing proper notice, another client is prevented from receiving care. In the event you need to cancel, please contact our office by phone at (251) 222-8880. **If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be considered a No Show** and held to our updated policy terms.

We realize that an emergency may occur, and you may not be able to notify us. Exceptions will be made on a case-by-case basis for true emergencies.

After One (1) No Show: The client will be notified of the missed appointment and billed a $50.00 No Show fee. This fee is not covered by insurance and must be paid prior to your next appointment.

After Two (2) No Shows: The client will be notified of second missed appointment and will be subject to a $100.00 No Show fee (*not covered by insurance and must be paid prior to your next appointment*).

After Three (3) No Shows: The client will be notified of third missed appointment and will be billed our standard 60-minute session rate of $160.00 (*not covered by insurance and must be paid prior to your next appointment*).

By signing this document, I acknowledge that I understand and am aware of the Cancellation and No Show Policy and will adhere to the terms listed above.

_____

Patient Name

_____

Signature of Patient, Parent, Guardian, or Other Authorized Representative Date

HurleyCounseling, LLC
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Billing Agreement

Thank you for choosing Hurley Counseling for your counseling needs. In order to prevent any misunderstanding concerning the responsibility of payment for counseling services provided to our patients, the following is supplied:

The patient or guarantor is responsible for payment for services by Hurley Counseling LLC. at the time of service unless prior arrangements have been made. The only exception is if Hurley Counseling has contracted with your HMO/PPO insurance plan to accept the insurance payment as payment in full after all deductibles have been met and all copays have been paid.

We will file a claim to your insurance company for each visit. If requested, we will furnish you with a copy of your bill for each visit, which contains all the information necessary for you to bill any personal reimbursement policies that you may have.

Certain health insurances (HMO, POS, etc.) require that you obtain a referral from your Primary Care Provider (PCP) or prior authorization from your insurance company before visiting a specialist or having a procedure done. Our billing manager will assist as a courtesy, but you are primarily responsible for obtaining all required information. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Providers at Hurley Counseling only accept Blue Cross Blue Shield. If your insurance is Out of Network, and you want your insurance to pay for services, you will have to pay out of pocket for your services at the time of service. At your request, our billing manager can send you a superbill to submit to your insurance company. It is the patient's responsibility to handle reimbursements from Out of Network Insurance providers.

If your balance exceeds $300, Hurley Counseling has the right to deny you an appointment until arrangements have been made or the balance is reduced below that threshold. If you have a balance existing for longer than two months and have been contacted by Hurley Counseling regarding your balance, Hurley Counseling reserves the right to turn you over to a collection agency or an attorney regarding default of payment.

Patient Agreement

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

In the event that your insurance company is billed, I authorize payment of medical benefits to be paid directly to Hurley Counseling. A photocopy of this agreement shall be considered as effective and valid as the original.

In the event that my account is placed with a collection agency or an attorney upon default of payment, I agree to pay all collection costs including attorney fees and court costs.

_____

Signature of Patient, Parent, Guardian, or Other Authorized Representative Date

_____

Responsible Party Signature (if applicable) Date

1327 Spring Hill Ave. Mobile, AL 36604
101B Villa Dr., Room 209, Daphne, AL 36526
office@hurleycounselingllc.com | 251.222.8880 | www.Hurley-Counseling.com

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Office Use Only
Patient ID _____
Copay _____

Billing Form

Patient Information

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient Phone Number: _____ Email: _____

How would you like to be contacted regarding billing? (Select all acceptable) ☐ Phone. ☐ Email. ☐ Mail.

Are you responsible for billing? ☐ Yes. ☐ No.

If no, Name of Responsible Party: _____ Relationship to you: _____

Responsible Party's Phone Number: _____ Email: _____

Responsible Party's Address: _____

How can we contact them regarding billing? (Select all acceptable) ☐ Phone. ☐ Email. ☐ Mail.

I am paying for Services at Hurley Counseling through:

☐ Insurance

☐ Private Pay

Insurance Information

Insurance Company: _____

Member I.D./Contract #: _____ Group #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Relationship to Patient: _____

Insured's Address: _____

I authorize the release of any medical information necessary to process this claim.

_____

Patient Signature Date

Credit Card Information

Card Type: _____

Name on Card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____ Zip Code for Card: _____

_____

Signature Authorizing the Use of Card Date

Email where Receipts should be sent: _____

Any Comments/Notes the Billing Office Need to Know

_____

_____

_____

_____

Signature of Patient, Parent, Guardian, or Other Authorized Representative Date