Christian Counseling Professionals

Appointment Date:

PATIENT/CLIENT REGISTRATION

Appointment With:

*****PLEASE NEATLY PRINT ALL INFORMATION*****

First Name: Middle Initial: Last Name:

Date of Birth (include year): Social Security Number: Church Affiliation:

Mailing Address w/City & Zip:

*****MUST HAVE PHYSICAL ADDRESS IF DIFFERENT THAN ABOVE*****

Physical Address w/City & Zip:

Best Phone # to contact you: (indicate cell, home, work)

Secondary Phone #: (indicate cell, home, work)

Marital Status: If married, spouse name:

Emergency Contact: Phone #: Relationship:

Email Address:

Employer: Work Phone:

Primary Care Doctor: Phone #:

Payment Structure – Check All That Apply: ☐ Self-Pay ☐ EAP ☐ Insurance

Payment Information: I hereby authorize Christian Counseling Professionals, Inc. to use the credit card information below to cover any copay, coinsurance, or self-pay amounts or amounts not covered by my insurance for payment

MUST COMPLETE IF WEEKEND OR AFTER 5 PM APPOINTMENTS ARE MADE.

Credit Card # & Type: Exp. Date:

Name as appears on card: CVV (from back of card):

Signature: Current Date:

APPOINTMENT NOTIFICATION OPTIONS: (Please select ONE)

	#1 EMAIL – must provide valid email address above
	#2 TEXT – must provide valid cell phone number above
	#3 VOICE – must provide valid phone number
	DO NOT CONTACT ABOUT UPCOMING APPOINTMENTS

Patient/Client Name:

Responsible Party Information (if different from patient/client):

Name: Relationship: Primary Ph #:

Secondary Ph #: Date of Birth: Social Security #:

Address w/City & Zip:

INSURANCE INFORMATION:

*****NOT necessary if card scanned*****

Have you contacted your insurance company about this appointment?

Primary Insurance Co: Phone #:

Address w/City & Zip:

Name of Insured: Insured DOB: SSN of Insured:

Insured ID #: Group #:

Secondary Insurance Co: Phone #:

Address w/City & Zip:

Name of Insured: Insured DOB: SSN of Insured:

Insured ID#: Group #:

Is this an Employee Assistance Program (EAP) Visit? Yes No Auth #: # of visits:

If you will be using your commercial insurance once your EAP visit have been exhausted, please fill out insurance information above.

How did you hear about us?

Reason for seeking care:

MEDICAL HISTORY

Do you have any drug allergies? Yes No

What medicines are you allergic to?

What type of reaction do you have?

What medications, including dosages, are you currently taking?

Past hospitalizations:

Are you sexually active? Are you pregnant or trying to get pregnant? Do you smoke?

Patient/Client Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Upon my request, I have been presented with a copy of Christian Counseling Professional's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted by federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

Restrictions: _____

Signature: _____ Current Date: _____

CONSENT TO TREATMENT

I hereby consent to treatment to treatment by the staff of Christian Counseling Professionals (CCP). I understand that CCP uses an interdisciplinary approach to treatment and that the staffing about my case may include physicians, nurse practitioners, therapists, psychologists, and social workers who may confer and consult regarding the best method of treatment. I understand that my treatment will be confidential except in cases of suspected harm to self or others, suspected physical or sexual abuse of minors or elders, or ordered by a court of law, or for insurance purposes. I understand my clinician is required by law to report the above abuses.

I will have the opportunity to discuss with my clinician the nature of my problem, results of the initial evaluation, the treatment plan, alternative treatment, and reasonable foreseeable risks of my treatment.

I understand that CCP's staffs are licensed professionals that practice from a Christian belief system.

I understand that my care is payable at the time of service and that I am responsible for the bill unless otherwise specified. A fee is due for any schedule appointment unless the appointment is cancelled twenty-four (24) hours in advance.

Please check here to accept the terms of CCP Consent to Treatment: ☐ Signature: _____ Minor's name (if applicable): _____

CREDIT CARD REQUIREMENT FOR NEW PATIENT PSYCHIATRIST APPOINTMENTS

Due to the prohibitive costs of new patient missed appointments, we require a credit card on file to schedule a new patient appointment with our medical office.

There is a tremendous shortage of psychiatrists in the Albuquerque area and when people do not show for schedule appointments it negatively impacts a number of patients in need who could have used that appointment time.

If a new patient fails to attend their schedule appointment, the credit card will be charged $100.00 + tax. This amount is not covered by insurance. If the appointment is kept as schedule or canceled with at least 24 hour notice, no charge will be made to your card.

You will be responsible for any applicable co-pays, co-insurance, deductibles, or self-pay amounts. Our regular no=show fee of $50.00 will remain in effect for all other appointment types.

☐ Please check here to accept the terms of the CCP Credit Card Requirement for New Patient Psychiatrist Appointments

Patient/Client Name: _____

CHRISTIAN COUNSELING PROFESSIONALS (CCP) POLICIES AND PROCEDURES

The following information is important and should be read carefully. Your understanding of our services and policies will help us reach your goals more effectively and prevent the use of your valuable session time for business matters.

CONFIDENTIALITY

Your records are confidential and will not be released or disclosed except by a HIPAA compliant release form which you have signed, or by court order from a judge.

APPOINTMENT TIMES

Appointments are scheduled on the hour or half hour for therapists and in 15, 30, 45, and 60 minute increments for physicians and nurse practitioners. Appointments with the therapists are scheduled for 45-53 minutes with the remaining minutes of the hour reserved for writing case notes and to complete necessary paperwork.

PUNCTUALITY

Punctuality is important to get the full use of your session time. While sometimes the therapists and doctors may experience emergencies or delays which may result in them running late, we recognize that your time is valuable and will make every effort to avoid unnecessary delays.

MISSED APPOINTMENTS

As a courtesy to our staff and other patients, we require at least 24 hours advance notification when you need to cancel or reschedule appointments. **You will be charged $50.00 for each appointment missed without 24 hours' notice**, which must be paid prior to rescheduling. We have an answering service available after hours and on weekends where you may leave a message. If at all possible, Monday appointments should be canceled by 5:00 pm on the previous Friday. This office reserves the right to discharge you from treatment after three missed appointments.

INITIAL MEDICAL APPOINTMENT NO-SHOWS

As a courtesy to our other patients and due to the extreme shortage of availability with our medical providers, we require a credit card to secure a new patient appointment. **In the event that patients do not appear for initial appointments, their credit card will be charged $100.00. If the appointment is canceled with less than 24 hours' notice, the credit card will be charged $50.00.**

INFORMED CONSENT

Under certain circumstances, it may become necessary for us to contact you outside of appointment times. It is our policy to leave a simple message stating the name of the provider and our return phone number.

GRIEVANCE PROCEDURES

At CCP, we strive to provide the highest standard of mental health care and quality customer service. We welcome your comments and concerns, and appreciate your input. Should you have any concerns that you feel require our immediate attention, you may feel free to call (505) 856-0300 or (888) 711-1231 to speak with our administrator. Your concern will be addressed with our management committee.

FEES

Lengthy telephone consultations are subject to the standard fee-per-hour. (Most insurance plans do not provide coverage for phone consultations.) If clinic staffs are required to meet with school or government officials, employers, or if any related reports are required, an appropriate charge will be made. Payment is due at the time of service. For you convenience, we accept MasterCard, VISA, American Express and Discover. We also accept personal checks and cash.

DISABILITY PAPERWORK

As our practice has grown, we are experiencing an increased amount of paperwork surrounding short and long term disability claims for our patients. We charge $25.00 per page for disability paperwork, which must be paid in full before the paperwork will be released. Any professional letters or narrative reports will be charged at the full hourly rate of the provider.

EMERGENCY PROCEDURES

If you have a medical emergency, please call 911 or go to the nearest emergency room. We have a physician on call for urgent matters, please call 505-856-0300 and leave a message for a return call.

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COORDINATION OF CARE FORM

Patient/Client Full Name: _____

Date of Birth: _____ Social Security Number: _____

Part I:

I do not authorize information about my physical/behavioral health treatment to be released to my primary care physician.

Signature: _____ Date: _____

Part II: Release of Medical/Therapy Information (If you signed Part I, do not complete Part II)
*****PLEASE CHECK WITH YOUR CLINICIAN BEFORE SIGNING THIS SECTION*****

I authorize release of my medical/therapy records, as checked below, from Christian Counseling Professionals.

Primary Care or Specialist Name: _____

Records to be released: All records ☐ Records related to drug/alcohol/substance abuse ☐

Health records related to emotional/medical/developmental disabilities/psychiatric conditions (not psychotherapy) ☐

Expiration: I understand that I may cancel this authorization at any time by sending my health care provider(s) my cancellation notice in writing. I understand that my health care provider(s) may have already released records according to this authorization prior to receiving my notice of cancellation. Unless cancelled this authorization will expire one year from the signature date.

Patient/Client Signature: _____ Date: _____

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Burns Depression Checklist

Read each statement and place the appropriate number in the box next to it.

0 – Not at all
1 – Somewhat
2 – Moderately
3 – A lot

	1) Sadness: Have you been feeling sad or down in the dumps?
	2) Discouragement: Does the future look bleak or hopeless?
	3) Low self-esteem: Do you feel worthless or think of yourself as a loser?
	4) Inferiority: Do you feel inadequate or inferior to others?
	5) Guilt: Do you get self-critical and blame yourself?
	6) Indecisiveness: Is it hard to make decisions?
	7) Irritability: Have you been feeling angry or resentful?
	8) Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?
	9) Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?
	10) Poor self-image: Do you think you're looking old or unattractive?
	11) Appetite changes: Have you lost your appetite? Or, do you overeat compulsively?
	12) Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much?
	13) Concerns about health: Do you worry a lot about your health?
	14) Suicidal impulses: Do you think life is not worth living or think you'd be better off dead?

	TOTAL SCORE (ADD ALL NUMBERS)

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The Mood Disorder Questionnaire

Instructions**:** Please answer each of the following questions to the best of your ability.

A. Has there ever been a period time when you were not your usual self and…

		YES	NO
1)	you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
2)	you were so irritable that you shouted at people or started fights or arguments?		
3)	you felt much more self-confident than usual?		
4)	you got much less sleep than usual and found you really didn't miss it?		
5)	you were much more talkative or spoke much faster than usual?		
6)	thoughts raced through your head or you couldn't slow your mind down?		
7)	you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
8)	you had much more energy than usual?		
9)	you were much more active or did many more things than usual?		
10)	you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
11)	you were much more interested in sex than usual?		
12)	you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
13)	spending money got you or your family into trouble?		

B. If you checked YES to more than one of the above

	YES	NO
...have several of these ever happened during the same period of time?		

C. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? ***Please circle only one response*****.**

None Minor Moderate Serious

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Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle your answer.

		Not at all	Several Days	More than half the days	Nearly every day
1)	Little interest or pleasure in doing things	0	1	2	3
2)	Feeling down, depressed, or hopeless	0	1	2	3
3)	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4)	Feeling tired or having little energy	0	1	2	3
5)	Poor appetite or overeating	0	1	2	3
6)	Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7)	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8)	Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9)	Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		Add Columns	+	+	
		TOTAL			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult

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Burns Anxiety Inventory

Instructions: The following is a list of symptoms that people sometimes have. Circle the number that best describes how much that symptom or problem has bothered you in the past several days.

0 – Not at all 1 – Somewhat 2 – Moderately 3 – A lot

Category I: Anxious Feelings

1)	Anxiety, nervousness, worry or fear	0	1	2	3
2)	Feeling that things around you are strange, unreal or foggy	0	1	2	3
3)	Feeling detached from all or part of your body	0	1	2	3
4)	Sudden unexpected panic spells	0	1	2	3
5)	Apprehension or a sense of impending doom	0	1	2	3
6)	Feeling tense, stressed, uptight, or "on edge"	0	1	2	3

Category II: Anxious Thoughts

7)	Difficulty concentrating	0	1	2	3
8)	Racing thoughts or having your mind jump from one thing to the next	0	1	2	3
9)	Frightening fantasies or daydreams	0	1	2	3
10)	Feeling that you're on the verge of losing control	0	1	2	3
11)	Fears of cracking up or going crazy	0	1	2	3
12)	Fears of fainting or passing out	0	1	2	3
13)	Fears of physical illnesses or heart attacks or dying	0	1	2	3
14)	Concerns about looking foolish or inadequate in front of others	0	1	2	3
15)	Fears of being alone, isolated or abandoned	0	1	2	3
16)	Fears of criticism or disapproval	0	1	2	3
17)	Fears that something terrible is about to happen	0	1	2	3

Category III: Physical Symptoms

18)	Skipping, racing or pounding of the heart	0	1	2	3
19)	Pain, pressure, or tightness in the chest	0	1	2	3
20)	Tingling or numbness in the toes or fingers	0	1	2	3
21)	Butterflies or discomfort in the stomach	0	1	2	3
22)	Constipation or diarrhea	0	1	2	3

23)	Restlessness or jumpiness	0	1	2	3
24)	Tight, tense muscles	0	1	2	3
25)	Sweating not brought on by heat	0	1	2	3
26)	A lump in the throat	0	1	2	3
27)	Trembling or shaking	0	1	2	3
28)	Rubbery or “jelly” legs	0	1	2	3
29)	Feeling dizzy, lightheaded, or off balance	0	1	2	3
30)	Choking or smothering sensations or difficulty breathing	0	1	2	3
31)	Headaches or pains in the neck or back	0	1	2	3
32)	Hot flashes or cold chills	0	1	2	3
33)	Feeling tired, weak or easily exhausted	0	1	2	3
	Totals Score (add numbers together) for each column				
	GRAND TOTAL				