Therapy
Medicaid

Client Name:_____

MR#_____

Winchester Community Mental Health Center, Inc.

Date_____

Client Name_____
Cell Phone: (____)_____ Email: _____ Home Phone (___) _____
Can we leave a message on your cell phone: Yes___ No__ Can we leave a message on your home phone: Yes___No__
Address_____City_____Zip Code_____
Gender: M/F Age____ Date of Birth _____/_____/_____ Social Security # _____
Occupation _____ Employer/ School _____
Work Phone (____) _____ Martial Status _____
Spouse's Name _____ Social Security # _____
Age _____ Date of Birth ____/____/____ Employer: _____
Occupation _____ Cell (____) _____ Work phone: _____
PRIMARY INSURANCE INFORMATION:
Insurance Company_____ ID/ Member # _____
Group # _____ Policy/ Plan # _____
Name of Insured _____ Insured's SSN_____
Insured's DOB_____
SECONDARY INSURACE INFORMATION:
Insurance Company_____ ID/ Member # _____
Group # _____ Policy/ Plan # _____
Name of Insured _____ Insured's SSN_____
Insured's DOB_____
EMERGENCY CONTACT _____ **Phone** (___)_____ **Relationship:** _____
Parent Information (IF PATIENT IS A MINOR)
Father_____**Home Phone** _____
Address _____ City _____ Zip _____
Date of Birth _____/_____/_____ Social Security # _____
Employer _____ Work Phone _____
Mother_____ **Home Phone:** _____
Address _____ City _____ Zip _____
Date of Birth _____/_____/_____ Social Security # _____
Employer _____ Work Phone _____
I was referred by _____ ***Relationship to you*** _____

<u>If you want us to bill your insurance:</u>

**** Please provide the Receptionist with your insurance card(s) and a picture ID. Insurance is billed as a courtesy. It is important that you understand the following: (Please check ✓ <u>and</u> initial _ the following statements.)**

- ☐ __ I will be charged a $40.00 fee for any missed appointments and for cancellations received less than 48-72 hours prior to my scheduled appointment time. **Insurance will not pay for these and they are my sole responsibility.**
- ☐ __ I am responsible to obtain any preauthorization from my insurance company. If failure to do so results in non- payment from my insurance company. I understand I am financially responsible to pay for these sessions. I am responsible to pay for all deductibles, any and all co-pays, co-insurance and any balance remaining after insurance has paid their portion and contractual adjustments have been made.
- ☐ __ I understand that the ultimate financial responsibility is mine and verification is not a guarantee of payment.
- ☐ __ I have read & understand the above. I authorize payment of benefits be made on my behalf to Winchester CMHC, INC. for any services
- ☐ __ **I have been offered a copy of HIPPA- Notice of Privacy Practices. I would like a copy. (Circle One) Yes or No**

Client/ Parent Signature _____ Date_____

Authorized Staff Signature _____ Date _____

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovatter Drive
Inwood, WV 25428

Client Name:_____

MR#_____

Winchester Community
Mental Health Center, Inc.

Assignments of Benefits: Release of Liability & Medical Information

I hereby authorize and request that insurance benefit payments by my insurance company

_____

(Name of insurance company)

be made directly to Winchester Community Mental Health Center ("Facility") for services provided to me or my dependent by the facility. I understand that my insurance company may only cover a portion of the total bill and that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Winchester Community Mental Health Center, Inc. to disclose any and all written information to the above-named insurance company and/or its designated representatives, at the determination of the facility. Such disclosure shall be for reimbursement purposes for services provided by the facility.

I hereby release the facility, its officers, agents, employees and any clinician associated with my treatment, from all liability that may arise as a result of discloser of information to the above named insurance company or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company or their designated representatives request records of information for reimbursement purposes.
2. I agree to participate and assist the facility or its designated representatives with any appeal process necessary to collect payment for services rendered. I hereby appoint the facility as my appointed representatives in any insurance provider or fiscal intermediary case reconsideration and/or appeal procedure to act on my behalf.
3. I am aware and have been advised of the provisions of Federal and State Statutes, rules and regulations that provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. I understand that the ultimate financial responsibility is mine and verification of insurance is **not** a guarantee of payment
    - Billing may be done by a firm contracted by the facility for billing and collection purposes.
    - Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
    - The facility shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____ _____

Client Signature **Legal Guardian** **Insured Policyholder Name & D.O.B.**

_____ _____

Witness Signature **Date of Signatures**

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovatter Drive
Inwood, WV 25428

Client Name:_____

MR#_____

Winchester Community Mental Health Center, Inc.

Medicaid Appointment Responsibility Contract

Date: _____

I, _____, understand and agree to the following:
(Client/Legal Guardian Name - Please Print)

- I am responsible for keeping my appointments.
- I am responsible for being on time.
- I will give at least 48 -72 hours notice by calling WCMHC, Inc if I cannot keep my appointment. My appointment will be considered a "No-Show" if 48-72 hours notice is not provided.
- I will receive a warning letter if I "no-show" to **2 appointments,** or have excessive rescheduled or cancelled appointments.
- I will be discharged if I "no-show" to **(3) appointments**, or have excessive rescheduled or canceled appointments. If I receive a discharge letter, I will not be eligible to receive services at WCMHC for 6 months.

_____ _____

Signature of Client Date Signature of Parent/ Advocate Date

_____

Witness Signature Date

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovatter Drive
Inwood, WV 25428

Client Name:_____

MR#_____

Winchester Community
Mental Health Center, Inc.

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices
("Acknowledgement")

I acknowledge that I have received a copy of WCMHC's HIPAA Notice of Privacy Practices

_____
Printed Client Name

_____ _____
Signature of Client Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Client **(Circle One):**

Parent Guardian Power of Attorney Other:_____

Please note: It is your right to refuse to sign this Acknowledgement