CHURCHILL COUNSELING SERVICES, Inc.
Application for Service

Client Name_____ Case # _____

I am applying for services at Churchill Counseling Services, Inc. (CCS). I herewith give consent to CCS to provide treatment to members of my family and/or myself. I have received a copy of Churchill's Privacy Notice and the Client Handbook, which includes Clients' Rights, Grievance Procedure, Treatment Information, and rules regarding Safety, Supervision, and Confidentiality.

If I am unable to keep appointments, I agree to notify my counselor at least 24 hours in advance. If I miss my appointment without giving prior notice, I may be billed for a missed session, or my services may be declined and I will be referred to another agency. My insurance company is not responsible for paying for a missed session. If I have not had an appointment or contact with Churchill Counseling for 90 days, I understand that my case will be closed, which includes sessions with the psychiatrist if applicable.

I understand information gathered here is confidential. Release of such information can only be made by my written permission or by legal/clinical requirement or for purposes of collection of delinquent accounts. I agree to comply with the terms of the application written above and I certify this agreement with my signature.

_____ _____ _____
Client (Parent or Guardian if child) Witness Date
&
Relationship to Client_____

Payment Agreement/Authorization to Release Information to Third Party Payer(s)

I agree to pay the standard fee as follows:

Diagnostic Evaluation: $250	Group Therapy: $100
Individual Psychotherapy - full session $150	Individual Psychotherapy - half session $100
Medication/Somatic: $100 (15 minutes)	Psychological Testing: $250/hour

I understand that the Standard Fee Schedule, listing all services, is posted in the waiting room.

I agree to pay my fee at the time service is rendered, unless other payment arrangements have been made. At least the insurance co-payment will be due at the time of service. If an organization or insurance company will be paying all or a portion of the cost of the service that is provided to me, I give my permission to provide the third party payers (indicated on Registration Information and/or copy of my insurance card) with such information as may be required for CCS to receive payment. I understand that I may revoke this consent at any time, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This release will remain in effect until the client's bill is paid in full.

I understand that any balance on my account is my responsibility. All balances require a minimum monthly payment of 25% of your balance, following the insurance payment. If CCS does not receive a payment following 4 billing cycles, the account will be placed with our collection agency.

_____ _____ _____
Client (Parent or Guardian) Witness Date
&
Relationship to Client_____

CCS looks forward to serving you and hopes that you find our services of the highest quality. 2/2024