

ANCHOR POINT

Counseling, Biofeedback, Neurofeedback & Integrative Medicine

3320 Old Salem Road, Conyers, GA 30013

Phone (678) 210-1166 Fax: (678) 210-0177

doctors@anchorpointga.com

CLIENT INFORMATION FORM

Date:	Client Social Security #:
Client Name:	Sex: Male Female Marital Status: S M D Other <small>please circle one</small> <small>please circle one</small>
Client Address:	
City:	Zip:
Phone/home:	Phone/cell:
Phone/work:	Fax:
Phone/other:	Email address:
Client Birthdate:	Employed, Full-time Student, Part-time Student, Retired, Other <small>please circle one</small>
Client Employer or School:	
Spouse or Parent Name:	Birthdate:
Spouse or Parent Employer:	Cell Phone #:
Emergency Contact:	Relationship: Phone #:
Client's Primary Care Physician:	Phone #:
Referred to Anchor Point by:	How did you hear about us?
Goals:	

RESPONSIBLE PARTY INFORMATION

If Patient is a Minor

Payor/Parent Name:		
Payor/Parent Address:		
Payor/Parent Phone # :	Wk phone #:	Fax #:
Payor/Parent Employer:		

INSURED'S INFORMATION (If Other Than Client)

Insured's Name:	Insured's SS#
Relationship to insured: Self Spouse Child Other	Insured's Birthdate:
Insurance Company Name	Attach Card Copy
Address:	
City, State, Zip:	
Phone #:	



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INSURANCE ASSIGNMENT AND RELEASE OF INFORMATION

I certify that I, and /or my dependent(s) have insurance coverage and assign directly to M. J. Kassam, MD, James Sendelbach, M.A, Ed.D., LPC, Susan Sendelbach, M.A, D. Min., and/or Peder Fagerholm, Ph.D. all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges;** which are filed as a courtesy, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

- 1) I understand that insurance may or may not cover all or part of these sessions and it is my responsibility to pay the charges, co-pay or co-insurance at the time of the session and to pay any amount not yet paid by insurance for any reason in 90 days. I may request that Anchor Point verify and file insurance forms for me by providing my insurance information on the Client Information Form. I understand that I am responsible for any charges not covered by my insurance even if the insurance company has given a prior verification as that is not a guarantee of coverage.
 - 2) I authorize M. J. Kassam, MD, James Sendelbach, M.A, Ed.D., LPC, Susan Sendelbach, M.A, D. Min., Patricia Liggett, CHAM and/or Peder Fagerholm, Ph.D. to disclose my health care information for the purpose of billing and obtaining payment from insurance carriers. Additionally, for the purpose of training, supervision, and where mandated by law some information may be shared.
 - 3) I understand that a fee of 5% per month will be added to accounts over 30 days old unless a signed payment agreement form has been received. I understand that if I do not pay according to this agreement, all legal and collection fees are my responsibility. There is a late fee of \$15.00 if payment is not received by scheduled date.
- I am requesting that Anchor Point file my insurance claims for each session. I authorize all payments to be made to Anchor Point and/or Dr. Kassam as designated by the service provided.
- I do not wish to have Anchor Point file insurance for me. I understand that if I decide to use my insurance in the future that I cannot file insurance retroactively and that a new signed agreement will be required.

PRIVACY POLICY

My signature below indicates that I am aware of Anchor Point’s Privacy Policy and it’s available for my review. I wish **not to be contacted** the following way: (Example: Home, Work, Cell)

_____ _____ _____

CLIENT RESPONSIBILITIES

Neurofeedback training, QEEG, and psychospiritual therapy are the services offered by Anchor Point. I authorize the use of appropriate touching for therapeutic healing, and application of biofeedback sensors if utilizing Neurotherapy sessions. By signing below, I understand that achieving my goals is a mutual relationship with the therapist or trainer. Success is not guaranteed and is determined by the effort that I put into our time together with the therapist/trainer serving as my guide or coach. I will notify my therapist or trainer of any changes in my medications or health condition.

I agree to pay for sessions at the time of the visit, and in respect for the therapist/ trainer’s time I agree to pay \$75 for sessions that are cancelled with less than 24-hr. notice and a full session fee for missed appointments when no notice is given. I may terminate the relationship at any time. It is requested however that the ending of psychospiritual therapy be discussed in person, and followed by at least two more sessions to facilitate a healing atmosphere of closure for all parties. The patient/therapist relationship will be considered terminated; by the patient, when patient does not schedule a new appointment after twelve months. I also agree to pay the full replacement cost of any furniture or equipment, if any item is damaged or broken by me or any of my family or visitors.

Signature of Adult Client or Responsible Party Print Name Date _____

Relationship to Client _____

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SERVICES AND PRICE AGREEMENT

Office sessions:

- Sessions are pro-rated by the quarter hour
- Clients cancelling appointments with less than 24-hour notice are billed \$75.00
- Clients missing appointments without calling or leaving a message may be charged the full cost of session
- 5% interest charges will be applied to all outstanding balances over 30 days old
- Client is responsible for all collection and court costs associated with unpaid balances
- Fees for services provided by other Specialist will be determined at time of appointment
- The cost of copying records is \$1 per color page and 50¢ per black and white page
- The fees for making court appearances, travel time and time spent reviewing materials, writing reports, summaries, and letters will be billed by the full hour and are due at time of service. Court costs for prepaid for the full day
- Telephone consultations and counseling will be provided at a pro-rated hourly rate
- The fee for checks returned for non-payment or a credit charge denial will be \$30.00 using Check Track system
- Collect telephone calls will not be accepted

Overtime: Sessions that extend beyond the hour allotted will be charged a pro-rated rate for the addition time

If I am late for a session, I understand that the session hour will begin when I arrive but will end at the same agreed upon session hour time in consideration for the trainer/therapist and other clients. If I expect to be late, I will attempt to call the therapist. Otherwise, the trainer/therapist will attempt to call me 10 minutes after the session time. If I cannot be reached, the session will be assumed to be a missed appointment and the trainer/therapist is not expected to wait for me. If I wish to have an extended training or counseling/consultation session I will request that additional time in advance of the session. If the therapist/trainer is late for my session, I will be given the full hour session.

No refunds are given for services that have already been performed or that require pre-payment (QEEG's)

*Anchor Point offers a sliding scale; for active client's in good standing, not utilizing their insurance, are uninsured, or low income. Our sliding scale is for office sessions only, testing and other fees are not included.

WE ASK THAT PAYMENT BE MADE AT THE TIME OF EACH OFFICE VISIT or; for your convenience, we can retain your credit/debit card information and charge you weekly for the session. If you would like us to do so, please complete the credit card authorization form attached.

WE ACCEPT THE FOLLOWING: American Express, Discover, Master Card, Visa, Cash, Check, or Visa Debit

TECHNOLOGY BASED COMMUNICATION

Please be aware that client initiated communications via text messaging and/or email **are not 100% confidential**. Phone and internet service providers retain logs of messages, content, and location services which may be accessible to unknown persons. Should you choose to contact our office via text or email we will reply; if requested, **only** should you indicate by initialing **here:**

I have reviewed, understand, and agree with the Client Notifications, Client Responsibilities and this Services and Price Agreement.

Signature of Adult Client or Responsible Party

Date

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CREDIT CARD AUTHORIZATION

BEGIN DATE: _____ END DATE: _____

CARD: VISA MASTERCARD DISCOVER AMEX
 DEBIT (VISA/MASTERCARD)

PATIENT NAME _____

CARD # _____

EXPIRATION DATE: _____

SECURITY CODE: _____

NAME ON CARD: _____

ID VERIFICATION: YES _____ NO _____ (initial confirmation)

CARD HOLDER ADDRESS: _____

ZIP CODE: _____

CARD HOLDER EMAIL ADDRESS: _____

I _____, do hereby authorize the amount of

\$_____ be charged to the above indicated account by Anchor Point Inc. after each session or on Friday's. I further authorize Anchor Point to charge the late cancellation fee as explained in "Services and Price Agreement". I understand that I can revoke this authorization at any time and will not lock the card to prevent usage as arranged.

Authorized Signature: _____

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Client History

(Please complete fully; Use back for additional space)

Name: _____ Date: _____

Height _____ Weight _____

Briefly describe the reason for your visit: _____

How long have you had this concern: _____

Prior treatment for this concern: _____

What are your strengths/special interests/activities: _____

Current Medications: (include over the counter medications, vitamins, herbal, and illegal drugs)

Do you drink beer, wine or liquor? Yes No Frequency: _____

Provide a recent medical and social history: _____

Provide a brief family medical history: _____

Name and ages of family/friends living with you:

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CLIENT NOTIFICATIONS

The Client or the Payor is responsible for all charges.

Please be prompt for your scheduled session. If you expect to be late, please attempt to call the therapist/trainer at 678-210-1166. Email is not an accepted means for changing your appointment or cancelling. If you are late, the session hour will begin when you arrive, but it will end at the previously scheduled time. If the therapist/trainer is late for the session, you will be given the full hour session.

Anchor Point is staffed by counselors with a variety of credentials including a LPC, Licensed Professional Counselor, a pastoral counselor/psychotherapist, and an M.D., Medical Doctor, who consults and oversees therapy. In addition, the counselors consult with a clinical LMFT (Licensed Marriage and Family Therapy) supervisor who will review cases with the counselors.

Please tell your therapist/trainer of any circumstances in your life that may affect your scheduled session. Illness, celebrations, grief and loss, no matter how small or large can affect the session.

Anchor Point strives to be a “safe haven” for our clients. To maintain a healing atmosphere weapons are not permitted on the premises.

If you are late, the therapist/trainer will attempt to call you ten minutes after the session start time. If you cannot be reached, the session will be assumed to be a missed appointment and the trainer/therapist is not expected to wait for you. If you know that you need to cancel a session, please call Anchor Point as soon as possible so that your time slot can be filled by someone else. **You will need to pay \$75 for sessions that are cancelled with less than 24 hour notice; a minimum of \$75 is due if you miss an appointment without notice.** Full charges for the hour or procedure may be charged for missed sessions. You may terminate training or counseling at any time, for any reason by informing us at 678-210-1166.

If you are paying by check or charge/debit card, there will be a \$30.00 fee through Check Track **for** any returned check for non-payment or any charge card payment that is not accepted. Legal action may be taken to collect on any account that is more than ninety days overdue, unless Anchor Point agrees to an alternative payment plan with you in writing. Late fees and interest fees will apply on all invoices. If your account is turned over to Collections or to the courts, courtesy adjustments and sliding scale reduced rates will not apply. There will be an additional charge of 5% interest per month plus costs of filing, expenses, and attorneys.

Most children require 40 or more hour sessions to complete Neurotherapy and most adults require at least 30 hour sessions. It is possible for some clients to finish earlier or to have particular needs that require longer training. Clients with difficult or long-term conditions may require 80 or more sessions. The number of sessions for counseling varies by the individuals and there is no pre-set recommended number of sessions. Goals are set between client and therapist.

Anchor Point’s policy for Privacy Practices is available at the front desk for your review. Please let Anchor Point know if there are any changes in your address, phone number, or other information. Feel free to ask any question about your treatment plan.

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Evaluation Checklist

CLIENT: _____ **DATE:** _____

COMPLETED BY: _____ **AGE:** _____

0 means "I consider this NOT an issue."

1 means "I consider this SOMETIMES an issue."

2 means "I consider this OFTEN an issue."

3 means "I consider this a MAJOR issue"

<input type="checkbox"/>	Speaks or acts impulsively	<input type="checkbox"/>	Thinks about death or suicide
<input type="checkbox"/>	Distracted by noises or movements	<input type="checkbox"/>	Sleepwalking or night terrors
<input type="checkbox"/>	Misses cues in social situations	<input type="checkbox"/>	Feels guilty or ashamed
<input type="checkbox"/>	Active or energetic or fidgety	<input type="checkbox"/>	Explosive emotional reactions to minor events
<input type="checkbox"/>	Difficulty falling asleep or restless sleeper	<input type="checkbox"/>	Repressed or intrusive memories
<input type="checkbox"/>	Quick emotional responses	<input type="checkbox"/>	Flat emotional response to positive events
<input type="checkbox"/>	Speaks quickly or loudly or interrupts	<input type="checkbox"/>	Difficulty sustaining intimate relationships
<input type="checkbox"/>	Allergies or asthma	<input type="checkbox"/>	Sometimes can't recall periods of time
<input type="checkbox"/>	Clumsy or accident prone	<input type="checkbox"/>	Oppositional/defiant
<input type="checkbox"/>	Impatient, seeks stimulation, easily bored	<input type="checkbox"/>	Hyperfocuses or has difficulty changing tasks
<input type="checkbox"/>	Messy handwriting	<input type="checkbox"/>	Argues frequently; doesn't give in
<input type="checkbox"/>	Rushes tasks, makes silly mistakes	<input type="checkbox"/>	Rigid thought; gets stuck on an idea
<input type="checkbox"/>	Night sweats or bedwetting	<input type="checkbox"/>	Compulsive behaviors
<input type="checkbox"/>	Drifts off into thoughts or daydreams	<input type="checkbox"/>	Difficulty balancing multiple tasks or assignments
<input type="checkbox"/>	Shy or withdrawn in social situations	<input type="checkbox"/>	Repeats words/phrases over and over
<input type="checkbox"/>	Difficulty waking up or sleeps deeply but is not rested	<input type="checkbox"/>	Phobias or irrational fears
<input type="checkbox"/>	Feels helpless or hopeless or cries easily	<input type="checkbox"/>	Holds a grudge or dislikes change
<input type="checkbox"/>	Speaks quietly or slowly	<input type="checkbox"/>	Tics/involuntary movements or noises
<input type="checkbox"/>	Procrastinates starting tasks	<input type="checkbox"/>	Obsessive thoughts or fears
<input type="checkbox"/>	Quickly forgets tasks or learned material	<input type="checkbox"/>	Addictive behaviors
<input type="checkbox"/>	Difficulty with reading, listening, writing for detail	<input type="checkbox"/>	Perceives events negatively
<input type="checkbox"/>	Difficulty completing tasks with multiple steps	<input type="checkbox"/>	Grinds teeth
<input type="checkbox"/>	Apathetic or indifferent or seems lazy	<input type="checkbox"/>	Wakes shortly after sleeping and can't sleep again
<input type="checkbox"/>	Loses focus when reading or listening	<input type="checkbox"/>	Relatively constant anxiety
<input type="checkbox"/>	History of early abuse	<input type="checkbox"/>	Anger outbursts after slow build-up
<input type="checkbox"/>	Distant or absent parents early in life	<input type="checkbox"/>	Productive but gets worn down by workload
<input type="checkbox"/>	Paranoid thoughts	<input type="checkbox"/>	Demands perfection of self and others
<input type="checkbox"/>	History of anxiety and/or depression	<input type="checkbox"/>	Frequent tension headaches

Evaluation Checklist (Page 2)

CLIENT: _____ **DATE:** _____

COMPLETED BY: _____ **AGE:** _____

0 means "I consider this **NOT** an issue."

1 means "I consider this **SOMETIMES** an issue."

2 means "I consider this **OFTEN** an issue."

3 means "I consider this a **MAJOR** issue"

<input type="checkbox"/>	Highly detail oriented or structured
<input type="checkbox"/>	Difficulty with creative tasks
<input type="checkbox"/>	Easily agitated
<input type="checkbox"/>	Dominant or demanding in relationships
<input type="checkbox"/>	Migraines or Irritable Bowel
<input type="checkbox"/>	Chronically fatigued
<input type="checkbox"/>	Low energy level and depressed or flat feelings
<input type="checkbox"/>	Cold hands/feet
<input type="checkbox"/>	Panic attacks
<input type="checkbox"/>	Sweaty palms or excessive sweating
<input type="checkbox"/>	Bloating after eating or stomach rumbling
<input type="checkbox"/>	Chronic difficulty with sleep
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Racing heart beat
<input type="checkbox"/>	Difficulty catching breath or shallow breathing
<input type="checkbox"/>	Dizziness or light-headedness
<input type="checkbox"/>	Sensitivity to touch, light or sound
<input type="checkbox"/>	Aggressive anger or irritability
<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Outbursts of rage without cause
<input type="checkbox"/>	Closes off to sensory awareness
<input type="checkbox"/>	Does not like to be touched or held

Please list any additional items you would like to add:



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SELF PAY FEE SCALE

Annual Gross Household Income	Individual or Couples Counseling Fee (Per Hour)	Additional Technology fee for Neuro Treatments
\$200,000 + Full Fee	\$280.00	\$20.00
\$149,000 - \$200,000	\$230.00	\$20.00
\$125,000 - \$149,000	\$180.00	\$20.00
\$95,000 - \$125,000	\$160.00	\$20.00
\$80,000 - \$95,000	\$140.00	\$20.00
\$60,000 - \$80,000	\$120.00	\$20.00
\$45,000 - \$60,000	\$100.00	\$20.00
Up to \$45,000	\$80.00	\$20.00

The cost for QEEG Brain Mapping is \$500 and must be paid prior to Client Portal Access.

Please circle the whole household income level that applies.

I understand that this is offered to me as a special arrangement either due to financial hardship or instead of Anchor Point filing my insurance. I further understand that I must include my whole household income to be considered for a discounted rate. I agree that the reduced fee is offered so long as I remain an active client in good standing. Any discount applied is subject to review at any time and that I could be held responsible for the full \$280/hour session fee

Print Patient Name: _____ **Print Guaratee's Name:** _____

Guaratee's Signature: _____ **Date:** _____