

# CHRISTIAN COUNSELING ASSOCIATES, Inc.

STEVENS FOREST PROFESSIONAL CENTER  
9650 Santiago Road, Suite 101  
Columbia, MD 21045

(410) 995-5587 or (301) 596-5759  
Fax (410) 992-1779  
mail@ChristianCounselingAssociates.org

## COORDINATION OF CARE

To all clients who plan to use their insurance coverage, a signed copy of this document must be included in your file.

Your insurance company has requested that we communicate with your Primary Care Physician (PCP) or other health providers about your treatment. Your PCP is responsible for taking care of you as a whole person and therefore it is important for your PCP to be aware of any other types of care that you are receiving which could affect your overall personal health. At the same time, please be aware that we cannot release information about you to your PCP, except in the case of emergencies, without your consent.

### CLIENT'S INSTRUCTIONS REGARDING RELEASE OF CONFIDENTIAL INFORMATION To Primary Care Physician or other Ancillary Care Provider

Client Name \_\_\_\_\_ Name of Physician \_\_\_\_\_  
Client SS# \_\_\_\_\_ Physician Address \_\_\_\_\_  
Client Date of Birth \_\_\_\_\_  
Physician Phone # \_\_\_\_\_ Physician FAX # \_\_\_\_\_

I understand that the staff of Christian Counseling Associates, Inc., will keep all information about my mental health treatment confidential to the best of its ability, but cannot guarantee its security once the information leaves CCA's office. I understand that I am entitled to a copy of this authorization form for my records.

Permission to release information about my mental health and/or substance abuse treatment to the physician listed above in order to facilitate coordination of care is: *(Please initial the appropriate line)*

\_\_\_\_\_ Authorized \*

\_\_\_\_\_ Withheld

This authorization becomes effective on the date listed below, and may be revoked by me in writing at any time, except to the extent of action already taken. Unless earlier revoked by me, this authorization automatically terminates the earlier of either one year from the effective date, or the term of coverage of my health insurance benefit plan. If I am signing for a minor child, I affirm that I am the parent or legal guardian of this minor client.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

\* If you authorize CCA to release information, then a copy of this form will be mailed to the physician named above with the following box filled in:

Dear Primary Care Physician:

The above-named person was seen for an initial appointment by \_\_\_\_\_, of our staff. His/Her presenting diagnosis is DSM IV: \_\_\_\_\_, \_\_\_\_\_ . He/She \_\_\_\_\_has \_\_\_\_\_has not scheduled an appointment for continued treatment of this disorder. Please feel free to contact the above-mentioned therapist for further information or to discuss treatment recommendations.

**Please complete reverse side**

Our Staff Members are Committed Christians and Fully Trained Professionals

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## REQUEST AND AUTHORIZATION FOR COUNSELING SERVICES

1. I do hereby request and authorize the staff of Christian Counseling Associates, Inc. to provide counseling services of a diagnostic and therapeutic nature to:

\_\_\_\_\_  
(Client's full name)

2. I understand that mental health services do not represent an exact science and I acknowledge that no specific guarantees have been given to me concerning the outcome of the services, which I am hereby requesting and authorizing.

3. I have received and read the "Statement of Policies," and understand the following points:

- a. Fees are charged for services rendered by Christian Counseling Associates, Inc.  
b. Payment is due at the time of service.

- \_\_\_\_\_ c. Missed appointments without timely cancellation will be charged.

*initial*

- \_\_\_\_\_ d. Insurance coverage is not certain until payment is received, and I am responsible for deductibles and unpaid balances. I am responsible for notifying CCA of any change in my insurance.

*Initial*

- \_\_\_\_\_ e. CCA's staff will operate within ethical guidelines regarding confidentiality of records concerning my treatment, but might be required by law to release any information regarding child neglect or abuse, or any threat to someone's life or well-being. Once I release any information to an insurance company, care management company, or doctor, CCA cannot assure confidential treatment of that information.

*Initial*

4. I have received CCA's "Statement of Client Rights and Responsibilities."

5. I agree to pay the fee which CCA charges for the services I am requesting and authorizing. I fully understand that I am financially responsible to Christian Counseling Associates, Inc. for all services rendered and I agree to pay any charges not covered and paid for by my insurance.

*initial*

6. I understand that my therapist may have a supervisory arrangement due to quality assurance and/or insurance reimbursement requirements. I hereby authorize my counselor to release any and all information related to my therapy to his/her supervisor, if applicable. I understand that this supervisor/supervisee arrangement maintains a high standard of confidentiality.

7. I hereby give my consent for the staff of Christian Counseling Associates, Inc. to use the information which I give to them, which is otherwise protected by law, or to release any and all such information for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. I understand that Christian Counseling Associates' Notice of Privacy Practices is posted in CCA's office and a copy of that document is available to me upon request. I understand that I may request a restriction on the use or disclosure of my protected information, but that the staff of Christian Counseling Associates might not agree to such restriction on its use or disclosure. I understand that I have the right to revoke this consent, in writing, but that if I do, such revocation could be cause for termination of my treatment by the staff of Christian Counseling Associates, Inc.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client (or of Client's parent/guardian)

***Please complete reverse side***

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