COLUMBIA COUNSELING CENTER
AND ASSOCIATES
900 ST. ANDREWS ROAD
COLUMBIA, SOUTH CAROLINA 29210
TELEPHONE (803) 731-4708 FAX (803) 612-1206

CONSENT TO TREATMENT OF A MINOR

To be completed by the parent/guardian:

Name of minor: _____

Age: _____ DOB: _____

I, _____, am the parent or legal custodian of the above-named minor.
Please print clearly

Please check one:

☐ I am the Mother of Father of the above-named minor and have ***joint custody*** of the minor pursuant to a decree that requires both my consent and the consent of another person.

☐ I am the Mother or Father of the above-named minor and have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.

☐ I am **NOT** the Mother or Father of the above-named minor and have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.

I hereby authorize Columbia Counseling Center and Associates to provide counseling services to the above-named minor.

_____ _____
Signature of parent or legal guardian Date

COLUMBIA COUNSELING CENTER
AND ASSOCIATES

MINOR INTAKE FORM

Date _____

Child's Full Name _____ Date of Birth _____ Age ____ Gender _____

Address _____ Apt/Unit #_____

City _____ State ____ Zip _____ Telephone _____

Whom does your child currently live with? Father ____ Mother ____ Stepfather____ Stepmother_____

Grandparent(s) _____ Guardian(s)_____ Other (describe) _____

Person to contact in case of emergency. _____ Telephone_____

May we leave a message for this emergency contact at number listed above on your child's behalf?_____

Parent/Guardian Email: _____

Primary Insurance Carrier: _____ Policy #_____

Name of Insured: _____ Insured DOB: _____

Family Information

Mother's Name _____Date of Birth _____ Marital Status _____

Address (if different from child) _____

Mother's Telephone & Email (if different from above) _____

Father's Name _____ Date of Birth _____ Marital Status _____

Address (if different from child) _____

Father's Telephone & Email (if different from above) _____

Names and Ages of Brothers and Sisters (if more space is needed, use back of page):

1. _____ Age ____ Gender ____
2. _____ Age ____ Gender ____
3. _____ Age ____ Gender ____

School attending _____Grade Level _____

If your child is not in school, why not? _____

Has your child failed a grade? Yes ___ No ___ If yes, what grade and why?_____

Does your child enjoy school at this time? Yes _____ No _____

What has been your child's greatest difficulty in school? _____

Discuss any other academic or behavioral problems your child has/had at school. _____

_____

Please list any significant medical issues requiring ongoing treatment? (seizure disorders, digestive diseases, migraines, etc.)

_____

Areas of Concern: In the following list, please place a check mark next to each item that indicates an area of concern for your child. Place two checks by items that are most important (you may add comments).

____Anxiety
____Bangs head
____Breaks the law
____Convulsive attacks
____Day-dreams
____Family problems
____Fire-setting
____Holds breath
____Harms self/others/pets
____Physical problems or disability
____Overly sensitive
____Running away
____Screaming
____Sleeping problems
____Temper problems/anger outbursts
____Unhappy most of time
____Withdrawn, lonely
____Parental divorce/separation
____Stress from recent event
____Feelings of Inferiority
____Unusual/Strange Experiences
____Repetitive ideas or actions

____Depression
____Difficulty getting along with others
____Disobedience
____Drugs, alcohol, tobacco use
____Eating problems
____Physically aggressive with others
____Health problems
____Thoughts of suicide
____Lying
____Periods of over-activity
____Frequent headaches/stomachaches
____Unusual Fears (darkness, animals, etc.)
____Sexual misbehavior
____ Learning Disability
____Throws self on the floor
____Wets bed
____Argumentative
____Victim of bullying
____Developmental Delays (walking, talking)
____Alcohol/Drug Use in family
____Feels rejected by family
____Fearful of things or situations

____Shy/Awkward with others
____Loss of interest in things
____Poor choice of peers
____Lonely/too few friends
____Smoking/Vaping/Drugs
____Alcohol use
____Troubling memories
____Inability to relax
____Memory difficulties
____Lack of Confidence
____Indecisiveness
____Bitterness/Resentment
____Unable to trust others
____Change in eating habits
____Can't stand up to others
____Can't say "no" to peers
____Panic attacks
____Low self-esteem
____Weight loss/Gain
____Spiritual Concerns
____Guilt Feelings
____Afraid of change

Has your child had previous counseling? _____ Does your child *want* to be here today? _____

How does your child prefer to spend his/her free time? _____

List any extra-curricular activities _____

What are some things that you think your child does well? _____

_____

In your own words, describe the main concern(s) for your child today _____

_____

Name the main goal you have for your child that you would like to reach in counseling: _____

_____

Other helpful information the therapist should know: _____

_____

I have completed the above information accurately, and have read and agree to the general information and policy statements of Columbia Counseling Center and Associates I give my consent to CCCA and its professional staff to provide services to my child, to include psychotherapy, evaluation, involvement in the treatment planning process, and testing, if appropriate.

Parent/Guardian Signature: _____ **Date:** _____

Doctor/Therapist Signature: _____ **Date:** _____

COLUMBIA COUNSELING CENTER
AND ASSOCIATES

Universal Medication Form

Name: _____

Date of Birth: _____

List all medications you are currently taking. This includes prescriptions, over the counter medicines (examples: aspirins, antacid) and herbals (examples: ginseng, ginkgo, St. John's Wort)

Date Started	Name of Medication and Dose	Reason For taking the Medication

Columbia Counseling Center

AND ASSOCIATES

Protected Health Information Authorization

The majority of this contract is mandated by South Carolina State Law and Public Law 104-91 (HIPAA).

PRIVACY POLICIES: *(Please initial each item below)*

_____ Information about you related to your treatment is classified by HIPAA as "Protected Health Information" (PHI). We strive to maintain the utmost confidentiality of your PHI. We are required by law to notify you of our privacy practices which are available for review on this clipboard. If the need arises wherein we need to share any PHI outside of your treatment, payment, health care operations listed in our Privacy Practices, we will obtain a separate authorization from you.

_____ All communication between you and your provider will be held in strictest confidence and will not be revealed to anyone unless required by law. Treatment information that you wish to disclose or obtain from anyone will only be initiated with your express written consent. At the time this information is required, you will be given a release of information that specifically designates to whom you would like the information released. Please note that some insurance companies may require release of clinical information to activate and process your benefits.

_____ I acknowledge receipt of the Notice of Privacy Practices of Columbia Counseling Center and Associates detailing how my PHI may be used and disclosed as permitted under federal and state law. I understand that CCCA is permitted to disclose my PHI without my authorization to facilitate treatment, payment, health care operations and delinquent debt collection.

TELEPHONE AND ELECTRONIC MEANS OF COMMUNICATON: *(Please initial each item below)*

_____ We have an automated appointment reminder system that will remind you of upcoming appointments, as a courtesy to you. By signing this form you are authorizing us to release your name, phone number and appointment information for appointment reminders. **As stated on our financial policy, an omission of a courtesy reminder DOES NOT constitute any waiver of fees for missed appointments or late cancellations.**

_____ While we strive to maintain confidentiality at all times, any means of electronic communication comes with risks including interception by outside sources or unintentional human error. Electronic communication is not considered completely confidential. Any such forms of communication runs the risk of breaching confidentiality and CCCA cannot be held liable for any breach.

Please list the name(s) with whom we may leave a message or who may call the office on your behalf, including anyone accompanying you to this appointment. Please circle one or both. **NOTE: No confidential information will be given to anyone unless expressly required by law.**

_____ Appointments only Billing/Insurance

Name/Relationship to Patient

_____ Appointments only Billing/Insurance

Name /Relationship to Patient

By signing this form, I attest that I have read, agree and authorize each item above.

_____ _____

Signature of Patient or Personal Representative ***Date***

_____

Print Name

Updated 1/2025

Columbia Counseling Center
AND ASSOCIATES

Late Cancellation and No-Show Policy

***Please initial each item below*:**

_____ Columbia Counseling Center and Associates (CCCA) strictly enforces a 24-hour cancellation policy for all scheduled appointments. I understand that CCCA reserves the right to charge my account $75 if I do not keep my appointment or if I cancel my appointment without giving a 24-hour notice.

_____ These fees are **not covered** by my insurance company or Employee Assistance Program.

_____ The omission of an appointment reminder does not constitute a waiver of these fees.

_____ These fees will be automatically charged to the credit card on file on the day of the missed appointment or late cancellation.

_____ After a third missed appointment, I may be at risk for termination of services, at my provider's discretion.

By signing this form, I attest that I have read, agree and authorize each item above.

_____ _____
Signature of Patient or Personal Representative *Date*

_____
Print Name

Updated 2025

Columbia Counseling Center

AND ASSOCIATES

Client Contract and Financial Policy

Patient Name: _____ **Date of Birth:** _____

Our goal is to provide our patients with understanding and clarity of our financial policies so that you may receive excellent service. If you have any questions concerning these policies, please do not hesitate to ask.

INSURANCE:

- I am responsible for knowing my benefits and for all copays, deductibles and payments as outlined in my insurance policy and understand that not all services are considered "covered" benefits in all policies, and in such cases, I am solely responsible for payment.
- I understand by giving my insurance card, I have given permission for Columbia Counseling Center and Associates (CCCA) and their contracted billing service, Therapist Solutions, to verify my coverage with my insurance company. I further understand that this is a general quote of benefits and does not guarantee payment for my service.
- I authorize the CCCA billing service to file insurance claims and to receive payment and assignment on my behalf, along with the release of records, including psychotherapy notes, or other medical billing data necessary to process claims to my insurance carrier.
- I accept full responsibility for my account balances, regardless of my insurance status or coverage problems that may arise during the course of my treatment.
- I agree to notify CCCA of any changes to my insurance policy along with changes to my PHI, such as address and/or phone number and emergency contact information.
- I understand that testing has a separate fee, and I am responsible for payment if insurance does not cover due to being a non-covered service or provider.
- I authorize payment of my medical/mental health benefits to be paid to CCCA on my behalf.

CREDIT CARD AUTHORIZATION:

- We require every patient to keep a credit card on file. In accordance with our Late Cancellation and No-Show Policy, this card will be charged. This is a requirement to be a patient in our practice.
- I understand that any copays, coinsurances and deductibles will be collected at time of visit via a card kept on file.

RETURNED CHECK FEE:

- I understand that if there is a returned check on my account, I am responsible for a service charge; and if the check is not taken care of immediately, it will be turned over to a collection agency.

COLLECTION AGENCY:

- In the event of any unpaid, delinquent debts, I authorize CCCA to release my information to a collection agency, and I understand I am responsible for all collection agency fees. Methods of contact will be determined by the collection agency, but may include the use of phone calls, pre-recorded voice messages, text messages or email.

NON-COVERED SERVICES:

- I understand that phone consultations, letters, reports and disability forms are not covered by insurance and that I am responsible for payment of any fees which may be related to such services.
- I understand that if I have given authorization for my medical record to be released, I am ultimately responsible for any fees associated with this request.

By signing this form, I attest that I have read and authorize each item herein and will adhere to these policies.

_____ _____

Signature of Patient/Responsible Party ***Date***

Updated 01/2025

Columbia Counseling Center
AND ASSOCIATES

PRIMARY CARE PHYSICIAN(PCP) AUTHORIZATION FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print): _____ **Date of Birth:** _____

By signing this authorization form, I understand that I authorize Columbia Counseling Center and Associates, to release or receive verbally or in writing my protected health information, as described in more detail in the paragraph below, to the following primary care physician:

NAME OF PRIMARY CARE PHYSICIAN: _____

Street address: _____ City: _____ State: _____ Zip code: _____

Telephone number: _____ Fax number: _____

PURPOSE OF THE USE AND DISCLOSURE: Communication necessary for treatment and coordination of care with PCP

SPECIFIC DESCRIPTION OF INFORMATION: Information pertaining to treatment, patient's current status, symptoms, diagnosis, test results and medications.

I understand that I may revoke this authorization at any time by providing a written notice to Columbia Counseling Center and Associates, 900 St. Andrews Road, Columbia SC 29210. I also understand that such a revocation will have no effect on any information already used or disclosed by Columbia Counseling Center and Associates prior to the receipt of such notice. Unless earlier revoked, this authorization will expire twelve (12) months after date of termination or as otherwise specified: _____.

If neither Federal nor South Carolina privacy law applies to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal or S.C. privacy law.

This authorization is voluntary and I may refuse to sign this authorization form. I understand that I am not required to sign this authorization form in order for the patient to receive treatment from Columbia Counseling Center and Associates. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the primary care physician named in this form.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Relationship to patient giving representative authority to act for patient *(if applicable)*

INFORMED CONSENT FOR TREATMENT
AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have read and agree to the General Information, Client Contract, Financial Policies and Notice of Privacy Practices including HIPAA disclosure of protected health information (PHI) to Columbia Counseling Center and Associates (CCCA). By signing this, I give consent for treatment to CCCA, (including internal office staff, their billing service, Therapist Solutions, and any debt collection agency in the event of an unpaid, delinquent debt) to include psychotherapy notes, coordination of care, obtaining and filing insurance information (if applicable), collecting copays/coinsurances, patient billing, testing (if appropriate), and debt collection. Any telehealth services utilized will be conducted through a HIPAA compliant telehealth platform which allows for real-time audio/video communication.

Copies of our Notice of Privacy Practices are attached to this clipboard and you will also be given a copy today.

Patient Signature: _____ **Date:** _____

Doctor/Therapist Signature: _____ **Date:** _____