New Patient Registration

Date:_____ Patient ID: _____

Please print legibly

Preferred Name:	Date of Birth (DoB):
Full Legal Name (First, MI, Last):	
Address:	

City:	State:	Zip code:

Mobile Phone:	Home Phone:	Email Address:

Social Security Number:	

Demographics

Marital Status (Choose One):

Single	Cohabiting	Married	Separated	Divorce	Widowed

Gender on Birth Certificate:

Female	Male	

Ethnic Origin:

African American	Asian American	Caucasian	Hispanic or Latino	Native American	Pacific Islander	Other

Student Status:

Full Time	Part Time	N/A	Name of School

Employment Status:

Full Time	Part Time	N/A	Name of Employer

Work Phone:	

Who do you have in your Support System?

Who referred you or how did you hear about us?

New Patient Registration

Date:_____ Patient ID: _____

Primary Care Physician Name:	Work Phone:
Physician Address:	City:
Psychiatrist Name:	Work Phone:

Do you want us to coordinate with your medical doctors listed above?	Yes	No
Primary Care Physician		
Psychiatrist		

Emergency Contact Information

Emergency Contact Name:		Relationship:
Address:		City:
Mobile Phone:	Home Phone:	Email Address:

Financial Responsible Person

Responsible Person's Legal Name:		Relationship:	
Address:		City:	Zip:
Mobile Phone:	Home Phone:	Email Address:	

For Clients 18 years of age and in high school or younger than 18 years of age

Parent/Guardian/Designated Representative:

Name:	Mobile Phone:	DoB:	Relationship:
Name:	Mobile Phone:	DoB:	Relationship:
Name:	Mobile Phone:	DoB:	Relationship:

New Patient Registration

Date:_____ Patient ID: _____

Please provide receptionists wit your insurance card(s) so we can copy them for our records.

Primary Insurance Information

Insurance Company:		
Policy Number:	Group Number:	
Subscriber Name:	DoB:	Relationship to Patient:

Secondary Insurance Information (Leave blank if not applicable)

Insurance Company:		
Policy Number:	Group Number:	
Subscriber Name:	DoB:	Relationship to Patient:

Tertiary Insurance Information (Leave blank if not applicable)

Insurance Company:		
Policy Number:	Group Number:	
Subscriber Name:	DoB:	Relationship to Patient:

Disclaimer: Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 60-days for payment. Please remember you are ultimately financially responsible for payment. On day 60, if the bill has not been paid by your insurance carrier, we will charge the responsible party the billed amount. A refund for any payments made on these claims by your insurance carrier after 60-days will be refunded to the responsible party within 30-days.

Patient Registration form completed by:	Patient Name:	Parent/Guardian/Representative Name:

The Caring Center of Wichita, LLC
Services Agreement

Payment
You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the Services Agreement. Accepted methods of payment are cash, check, Visa, MasterCard, Discover, and American Express. Please make checks payable to The Caring Center of Wichita.

Minor Children
The parent(s) or guardian who bring in a child to therapy is responsible for the account. It is our policy to consider an 18-year-old who is still in high school a "minor". Insurance billing for the minor is the same as the above section on insurance.

Sliding Fee Discount Program
The Caring Center of Wichita, LLC offers discounts to qualified clients. Discounts are offered based upon annual family income and size. The Sliding Fee Schedule is created and annually updated using the Federal Poverty Guidelines to determine eligibility. Please review the Sliding Fee Discount Policy for more information. Please note that the Sliding Fee Discount Program applies only to Psychotherapy sessions.

Insurance Reimbursement
The Caring Center of Wichita LLC accepts and processes insurance payments through a variety of insurance providers and Employee Assistance Programs (EAP). If you are using insurance or an EAP to pay for our services, we will:

1. Expect and accept payment of your copayment amount at the time of service.
2. File your claim with the insurance carrier.
3. Receive payment from your insurance provider.
4. Expect that you will pay your portion due of co-pay. co-insurance. deductible. or fee difference at the time of your appointment.

Please Note
Your insurance coverage is a contract between you and your insurance carrier. The Caring Center of Wichita. LLC files insurance claims as a courtesy to you. You (not your insurance company) are ultimately responsible for your bill. If your insurance carrier denies a claim filed on your behalf, then you are ultimately responsible to pay for the difference between the standard rate and the amount previously paid as copay.

The Caring Center of Wichita, LLC
Services Agreement

1. I agree to allow The Caring Center of Wichita, LLC to bill my insurance directly for services under the Services Agreement.
2. I give The Caring Center of Wichita, LLC permission to release any information the insurance company may require in order to process payments.
3. I appoint The Caring Center of Wichita, LLC as my authorized representative to act for me in obtaining payment.
4. I agree to assist with the claims process as required by The Caring Center of Wichita, LLC, or my insurance provider.
5. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met.
6. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Patient			**Parent/Guardian/Representative**	
Printed Name:	Date:		Printed Name:	Date:
Signature:			Signature:	

Cancellations & Missed Appointments

Insurance carriers will not pay for late cancellations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancellations must be made at least 24 hours in advance. Although 24 hours is the minimum, if your need to cancel or reschedule please give as much notice as possible. You may notify our office of cancellation by phone. Late cancellations (fewer than 24 hours before the appointment) will incur a fee of $25.00.

After two no call/no show appointments you will be charged a reinstatement fee of $100. You must pay this fee before being accepted back into the treatment program.

Patient			**Parent/Guardian/Representative**	
Printed Name:	Date:		Printed Name:	Date:
Signature:			Signature:	

The Caring Center of Wichita, LLC
Services Agreement

Private/Self-Payment for Services

I will self-pay for services at The Caring Center of Wichita, LLC. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Patient			**Parent/Guardian/Representative**	
Printed Name:	Date:		Printed Name:	Date:
Signature:			Signature:	

Past Due Accounts

If your account has not been paid on for more than 120 days and arrangements for payment have not been agreed upon, The Caring Center of Wichita LLC may resort to legal means to secure payment. This may include, but is not limited to, hiring a collection agency or attorney, or going through small claims court, or other legal remedies. If such legal action is necessary, you will be responsible for the costs.

Patient			**Parent/Guardian/Representative**	
Printed Name:	Date:		Printed Name:	Date:
Signature:			Signature:	

Best way to contact you:

Mark if "Yes"	**Method**	**Phone number or email address**
	Phone Call	
	Phone Text	
	Email	

Patient			**Parent/Guardian/Representative**	
Printed Name:	Date:		Printed Name:	Date:
Signature:			Signature:	

The Caring Center of Wichita LLC

Client's Rights

You have the right:

1) To be treated with dignity and respect,
2) To be free from abuse, neglect, exploitation, restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation,
3) To a safe, sanitary, and humane living environment that provides privacy, and promotes dignity,
4) To receive treatment services free of discrimination based on the client's race, religion, ethnic origin, age, disabling or a medical condition, and ability to pay for the services,
5) To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without consent, except for photographing for identification and administrative purposes, as provided by R03-602, or video recordings used for security purposes that are maintained only on a temporary basis,
6) To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights,
7) To confidential, uncensored, private communication that includes letters, telephone calls, and personal visits with an attorney, personal physician, clergy, Department of Children and Families Staff, or other individuals unless restriction of such communication is clinically indicated and is documented in the client record,
8) To practice individual religious beliefs including the opportunity for religious worship and fellowship as outlined in program policy,
9) To be free from coercion in engaging in or refraining from individual religious or spiritual activity, practice, or belief,
10) To receive an individualized treatment plan that includes client participation in the development of the plan, and periodic review and revision of the client's written treatment plan,
11) To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health,
12) To receive a referral to another program if the licensee is unable to provide a treatment service that the client requests or that is indicated in the client's assessment or treatment plan,
13) To have the client's information and records kept confidential and released according to R03-602,
14) To be treated in the least restrictive environment consistent with the client's clinical condition and legal status,
15) To consent in writing, refuse to consent, or withdraw written consent to participate in research, experimentation, or a clinical trial that is not a professionally recognized treatment without affecting the services available to the client,
16) To exercise the licensee's grievance procedures,
17) To receive a response to a grievance in a timely and impartial manner,
18) To be free from retaliation for submitting a grievance to a licensee, the Kansas Department of Aging and Disabilities, or another entity,
19) To receive one's own information regarding medical and psychiatric conditions, prescribed medications including the risks, benefits, and side effects, whether medication compliance is a condition of treatment, and discharge plans for medications,
20) To obtain a copy of the client's clinical record at the client's own expense,
21) To be informed at the time of admission and before receiving treatment services, except for a treatment service provided to a client experiencing a crisis situation, of the fees the client is required to pay, and refund policies and procedures, and
22) To receive treatment recommendations and referrals, if applicable, when the client is to be discharged or transferred.

The Caring Center of Wichita, LLC
Privacy Practices & Consent

Acknowledgement of review of notice of privacy practices and
Consent for use and disclosure of health information

Please read the following statements carefully; then sign below.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health Information (PHI) to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices

You have the right to read our *Notice of Privacy Practices* before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health Information, and of other important matters about your PHI.

We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we change our privacy practices, we will issue a revised *Notice of Privacy Practices*, which will contain the changes. Those changes may apply to any of your protected health Information that we maintain.

You may obtain an additional copy of our *Notice of Privacy Practices*, including any revisions, at any time by contacting:

The Caring Center of Wichita
714 S. Hillside
Wichita, KS 67211
Telephone: 316-295-4800 Fax: 316·295-4811
Contact Person: Peter J. Ninemire, Director

Right to Revoke: You will have the right to revoke this consent any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Consent

- ☐ I have had full opportunity to read and consider the contents of this consent form and your *Notice of Privacy Practices*.
- ☐ I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.
- ☐ I have reviewed a copy of The Caring Center of Wichita's *Notice of Privacy Practices*.

Patient			**Parent/Guardian/Representative**	
Printed Name:	Date:		Printed Name:	Date:
Signature:			Signature:	

The Caring Center of Wichita, LLC
Fee Schedule

Psychotherapy

Service	Fee	Comment
Initial Visit/Intake	$200	
30-minute Individual	$100	
45-minute Individual	$150	
60-minute Individual	$200	
Additional 60-minute Individual	$100	
Play Therapy	$220	
Family with Patient Present	$200	
Family without Patient Present	$200	
Group Therapy	$50	
Crisis Psychotherapy	$250	
Additional 30-minute Crisis Psychotherapy	$50	

Evaluations

Service	Fee	Comment
Mental Health Evaluation	$200	
Substance Use Evaluation	$150	
Mental Health and Substance Use Evaluation	$250	

Charges not covered by Insurance

Service	Fee	Comment
DUI Assessments	$150	Cash only
Smoking Cessation	$100	
Urinary Analysis (UA) Test	$25	

Service	Fee	Comment
Forms, Letters, and Reports	$50	Per document
Medical Records Request	$15	Per request
Case Management	$120	Per hour

Case Management includes indirect services provided outside session times to coordinate Adjunct and Court Advocacy services. For example, you may request that the counselor testifies or be present in court proceedings on your behalf of subpoena from the court or coordinate care with other providers.

Additional Fees

Service Fees	Fee	Comment
Late Cancellation or Missed Appointment	$25	Per event
Reinstatement after two, No Call/No Shows	$100	Per event
Non-sufficient Funds (bounced) Check	$25	Per event

Date: _____ Client ID: _____

Sliding Fee Discount Application

It is the policy of The Caring Center of Wichita, LLC to provide essential behavioral health and substance use disorder services with consideration of the clients' ability to pay. Discounts are offered based upon household size and annual income. Please complete the following information and return to the receptionist desk to determine if you or members of your family are eligible for discount.

The discount will apply to all services received at this location, but not those services purchased from outside, including laboratory testing. This form must be completed every 12 months or if your financial situation changes.

Head of Household Name:		
Employer:		
Address:		
City:	State:	Zip Code:
Social Security:	Home Phone:	Mobile Phone:

Please list spouse and dependents under 18 years and under.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Date: _____ Client ID: _____

Source	Self	Spouse	Other	Grand Total
Gross Wages, Salaries, Tips, etc.				
Income from business, self-employment, and dependents				
Compensation, Social Security, VA, Supplemental Income, Public Assistance, Pension or Retirement Income				
Interest, dividends, rents, royalties, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income are required before a discount is approved.

Date: _____ Client ID: _____

I certify that the information provided above regarding household size and annual income are correct. I have provided copies of financial proof of my income and/or copies of my insurance card (if applicable). I certify that I have read the policy and agree to the terms and conditions of the Sliding Fee Discount Program.

Name (Print): _____

Signature: _____

Date: _____

For Office Use Only

Patient Name: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Card		

Date: _____ Client ID: _____

Poverty Level*	150%	160%	170%	180%	190%	200%	>200%
Discount							
Family Size	Nominal Fee	50%	40%	30%	20%	10%	0%
Individual	$80	$100	$120	$140	$160	$180	$200
Group	$20	$25	$30	$35	$40	$45	$50
1	$18,210	$19,424	$20,638	$21,852	$23,066	$24,280	$24,281
2	$24,690	$26,336	$27,982	$29,628	$31,274	$32,920	$32,921
3	$31,170	$33,248	$35,326	$37,404	$39,482	$41,560	$41,561
4	$37,650	$40,160	$42,670	$45,180	$47,690	$50,200	$50,201
5	$44,130	$47,072	$50,014	$52,956	$55,898	$58,840	$58,841
6	$50,610	$53,984	$57,358	$60,732	$64,106	$67,480	$67,481
7	$57,090	$60,896	$64,702	$68,508	$72,314	$76,120	$76,121
8	$63,570	$67,808	$72,046	$76,284	$80,522	$84,760	$84,761
For each additional person, add	$6,480	$6,912	$7,344	$7,776	$8,208	$8,640	$8,640

*Based on 2023 Federal Poverty Guidelines

The Caring Center of Wichita, LLC
Grievance Policy

If a patient and/or person feels they have had their rights violated, their confidentiality broken, or have been exposed or abused to any type of unethical behavior by the counselors employed by The Caring Center of Wichita LLC, they are able to fill out a grievance report. They will not be discharged from treatment/employment, nor will they be discriminated against in any way. Completion of the grievance review will be done within 30 days of submission. In the event of irreconcilable grievances, a contract can be nullified upon two weeks written notice. If the individual who is submitting the grievance does not feel that the action taken was appropriate they may appeal to the following:

Kansas Department on Aging and Disability Services (KDADS)
Substance Use Disorders Behavioral Health
503 S. Kansas
Topeka, KS 66603-3404
Phone: (785) 296-4986 Fax: (785) 296-0256
Website: https://kdads.ks.gov/

Behavioral Science Regulatory Board (BSRB)
700 SW Harrison, Ste. 420
Topeka, KS 66603
Phone: (785) 296-3240 Fax: (785) 296-3112
Website: https://ksbsrb.ks.gov/

The Caring Center of Wichita LLC will cooperate with KDADS or BSRB during the investigation of a grievance that has been filed in regard to The Caring Center of Wichita LLC. The Grievance Form which follows should be used in the event a grievance needs to be filed. Upon completion of the form, it should be submitted directly to the Executive Director.

The Caring Center of Wichita, LLC
Grievance Form

Name:	Today's Date:
Email:	Mobile Phone:

Briefly describe the problem or concern that led to this grievance. Include any dates, timeline of events, and persons involved.

_____

_____

_____

_____

_____

_____

Desired Outcome (if any): _____

_____

_____/_____
Signature of Person submitting Grievance Date

Response from The Caring Center of Wichita

_____

_____

_____

_____/_____
Signature of The Caring Center of Wichita Date