Stress Management Center at Fernview
1115 Dunlap Road Anderson, SC 29621 / P.O. Box 1424 Anderson 29625 Phone 864-225-0792 Fax 864-226-3968

Client Information
First Name _____MI_____ Last Name_____ Date of Birth: _____
SS#_____ Marital Status: M/S/W/D
Sex:_____ Gender Identity:_____ Cell Phone _____
Alternate Number _____ May we leave a detailed message: Yes or No
Street Address_____
City_____ State_____ Zip _____
Email Address_____
EMERGENCY CONTACT_____
Phone_____ Who is financially responsible for this account? _____ Relationship to Patient and contact information: _____
Employer/School Information of Client
Name of Employer_____Occupation_____Yrs_____
Address_____State_____Phone_____
Name of School (If student)_____ Current Grade_____
Payment & Insurance Information (If policy is not in client's name)
Relation to Client_____Contact Number: _____
First Name _____MI__ Last Name_____
DOB_____ Street Address_____City_____State_____Zip__
Employer of Insured: _____Phone:_____

Insurance Filing and Payment:
We are a provider for many major insurance companies (not including any Medicaid program). Be sure to provide your correct, current insurance information. Client/Parents of minors are required to pay their coinsurance or copayments at the time of service. It is the responsibility of the patient/parent to make payment for any non-covered services received which may include but is not limited to: phone consultations, records requests, letter requests and late/missed appointment fees.
I understand that payment for my portion of insurance, cash pay or other services is due on the day of service, unless other payment arrangements have been made at the office.
Signature of Client _____Date_____
Signature of Client Representative
_____Date_____

Stress Management Center

(Please initial beside all the following)

_____-Unpaid balances over 90 days are considered delinquent and are eligible for outside collection.

_____-Initial Assessment does not guarantee a follow-up appointment at this practice.

_____-Clients may not contact providers through social media. LLR has banned communication on social media. Please contact them through the office ONLY.

_____- Telehealth appointments are filed with insurance as regular sessions and regular rates apply

_____- Crisis sessions will be filed under insurance reimbursements at allowable rates

_____ -Phone consultations are $25 per 15 Minutes.

_____-There will be a $25 charge for each text message sent to a provider.

_____-There will be a $30 charge for any check returned for non-payment by any institutions.

_____-A fee of $75 will be charged to the account for appointments canceled within 24 hours of scheduled appointment time. There will be a full charge, $135 for regular appointments and $150 for new patients, for no show/no call to scheduled appointments

_____- In extreme situations we will instate a payment plan, signed by both parties based on approval of finances

_____-For patients that wish to use an EAP; the EAP information must be provided BEFORE the initial appointment.

_____-EAP's are at the providers' discretion, providers are not required to accept EAP at anytime. (As of March 1st, 2023 the practice will only accept (5) EAP sessions per patient, per calendar year, regardless of the amount provided by EAP company.)

_____ -There will be a charge to the client(s) for all paperwork that is completed by the provider. (This charge could vary depending on the type/amount of paperwork that needs to be completed) _____-This office reserves the right to dismiss any patient who is non-compliant regarding treatment and/or office policy/ procedures.

_____-Our office transmits information electronically. If information is received in error by a third party, I absolve this practice of all liability.

_____-I understand information will be provided to Insurance companies for payment of my treatment.

Signature of Client _____Date _____ Signature of Parent or Legal Guardian_____ Date_____

I give / do not give my permission to Stress Management Center to share my psychological/psychiatric diagnoses or release information/records to the following person(s): Name: _____Phone_____ Purpose/ Relationship_____

Name: _____Phone_____ Purpose/Relationship_____

I understand my medical records may contain psychological/psychiatric, substance abuse and/ or other information shared as part of my medical records for treatment. I will need to sign an authorization to release any information except to my Insurance Provider.

Signature of Client _____Date_____

Signature Parent or Legal Guardian_____Date_____ Signature of (2nd) Parent or Legal Guardian_____Date_____

Stress Management Center

Client Information Medical/Mental Health/Medication

Client Name _____Birth Date_____

Primary Care Physician _____May we contact: Yes: _____ No: _____

(Initials) (Initials) Personal Medical/Mental Health_____

_____

_____ Family Medical/Mental Health History

_____

_____

_____ Drug Allergies_____

Food Allergies_____

Habits

Smoking___ Packs per day_____ How long _____ Coffee_____

Other Caffeine_____Type_____Amount total_____ Drugs _____

Type_____ Frequency_____

Alcohol____Type_____Frequency_____Amount_____ Sleep Disturbance____ Snoring____Awakening____Daytime Drowsiness_____

Agreement to treat and release

I have read and understand these forms and all questions have been answered. I give my consent to treatment and to speak with a counselor. I also give my specific provider authorization to discuss my care with other interoffice clinical providers .

Signature of Client_____Date_____

Signature Parent or Legal Guardian_____Date_____

Signature Parent or Legal Guardian_____Date_____

Universal Medications Please attach or utilize an additional space to share necessary medications

Name of Medication

Dosage

Prescriber

Condition

Stress Management Center at Fernview In cases of couples or and/or family counseling, all those who attend need to sign and date stating they understand the confidentiality of the sessions at the Stress Management Center. For individuals under 18 years of age, both parents will need to sign for the minor in cases of joint custody.

Print Name _____Sign_____Date_____

Print Name _____Sign_____Date_____

Print Name _____Sign_____Date_____

Print Name _____Sign_____Date_____

Card Authorization

This form is required to be on file with Stress Management Center for your convenience and to honor your agreement for services as many sessions are virtual, unless other agreements/ arrangements are made with office staff prior to your session. Please complete all fields. You can cancel this authorization at any time by contacting the office. This authorization will remain in effect until canceled. For any payments made to your account(s) there will be a 3.5% charge except for some HSA cards which are exempt for each transaction using debit/credit cards. IF you wish to not use this card for co pays, balances, etc, please notify our office staff. We are honored to serve you.

Credit Card Information

Card Type: __ MasterCard __ VISA __ Discover __ AMEX ___ HSA/FSA _____

Cardholders Name (as shown on card):

_____

Card Number: _____ Security Code:

_____

Expiration Date (MM/YY): _____

Zip code associated with billing address: _____

I, _____, authorize Stress Management Center at Fernview to charge my credit card above for co pays and/or balances. I understand my information will be saved to my file for future transactions on my account and will not be removed unless office personal is notified.

_____ Customer Signature

_____ Date

Information on Payment Policy

Payment is due the day of treatment. A 2.5% adjustment may be added daily to any unpaid balances for each account.

Effective Date: January 24, 2024

1. Payment Services:

All payments for services rendered are due at the time of the patient's visit unless prior arrangements have been made. We accept cash, checks, debit cards, and major credit cards. There is a 3.5% charge for any debit or credit cards.

2. Insurance:

Patients with health insurance are responsible for providing current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we will bill your insurance company for you, but we cannot guarantee payment of your claim. The balance is your responsibility whether your insurance company pays your claim or not.

3. Copayments and Deductibles:

All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. And failure to collect copayments and deductibles from patients can be considered a breach of contract.

4. Non-covered Services:

Please be aware that some services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit.

5. Unpaid Balances:

If your account has an unpaid balance, we can provide you with a statement.

6. Interest on Unpaid Balances:

A 15% interest charge will be added to your account for any unpaid balance older than 30 days. Interest will be charged each month until the unpaid balance is paid in full.

7. Payment Plans:

If you are unable to pay your balance in full, please contact our billing office immediately at Stress Management Center. We may be able to assist you in establishing a payment plan.

8. Collections:

Accounts that remain unpaid after 90 days may be referred to a collection agency. You will be responsible for all costs associated with the collection of your account, including but not limited to attorney and collection agency fees.

9. Changes to Policy:

The Stress Management Center reserves the right to change this payment policy at any time. 10. Agreement to Policy:

By seeking medical services from Stress Management Center, you are agreeing to the terms of this payment policy.

Signed:

Date:

Stress Management at Fernview

Art of Living Well Classes/ Seminars/ Workshop in Person & Virtual Release/ Waiver

By participating/ clicking into each class/seminar/workshop in person or virtual course, you are agreeing to the following conditions. You can download these forms for access.

1. In consideration of participating in any Integrative Medical Therapies/ Activities and all props used during activities in online, live, or other courses and offerings provided by Stress Management Center at Fernview and Art of Living Well... I agree and acknowledge that I am fully aware that participation in this activity involve risks and I accept all the risks of participating, even if the risks are created by the carelessness, negligence or gross negligence of a Released Party (as defined below) or anyone else.
2. “Claims” includes but is not limited to any and all liabilities, claims, demands, legal actions, rights of actions for damages, personal injury or death in connection with participation in the Activity. “Released Party” means Fernview Center for Wellbeing or any of its affiliates, franchisees and their respective representatives, directors, officers, agents, employees or volunteer staff.
3. I agree and acknowledge that:

1. I am in proper physical condition to participate in the Activity, and am aware that participation could, in some circumstances, result in physical injury, serious
2. 2. I understand my physical limitations and am sufficiently self-aware to stop physical activity before I become ill or injured.
3. I am aware that if the Activity occurs outdoors, the streets adjourning the area of the Activity are open to regular vehicular traffic during the Activity and I will obey all traffic laws and regulations.
4. I accept full responsibility for any product or technology loaned to me as part of participation in this Activity and commit to return the same in good working order.

4. I hereby, for myself and for my heirs, next of kin, executors, administrators and assigns, fully release, waive and forever discharge any and all rights or Claims I may have, now or in the future, against any Released Party, even if the Claims are based on the carelessness, negligence or gross negligence of a Released Party or anyone else. Without limiting the foregoing, I further release any resources which I may now or hereafter have resulting from any decision of any Released Party.

5. I agree not to sue any Released Party for Claims, even if the Claims arise from the carelessness, negligence or gross negligence of any Released Party or anyone else. I agree to indemnify (reimburse for any loss) and hold harmless each Released Party from any loss or liability (including any reasonable legal fees they may incur) defending any Claim made by me or anyone making a Claim on my behalf, even if the Claim is alleged to or did result from the carelessness or negligence of any Released Party or anyone else.

6. I am aware that there is no obligation for any person to provide me with medical care during the Activity. I understand and acknowledge that:

1. There may be no aid stations available for the Activity.
2. Some activities provided will take place in a location of my choice.
3. I am responsible for supplying my own medical care or supplies if needed during the activity.

7. I am aware that it is advisable to consult a physician prior to participating in the Activity. If I have consulted a physician, I have taken the physician's advice.
8. I grant my permission to the Released Party and any transferee or licensee or any of them, to utilize any photographs, motion pictures, videotapes, recordings and other references or records of the Activity which may depict, record or refer to me for any purpose ("Likeness"), including commercial use by the released parties, their sponsors and their licensees. This permission is for use anywhere in the world and on the Internet and for an unlimited period of time. I understand and agree that I will not be compensated or receive additional consideration for consenting to the use of my Likeness and that I will not be given a chance to receive, inspect or approve the promotional or marketing material, messages and/or content that may use my Likeness.

9. No warranties or representations have been made to me about the Activity which are not stated on this form. I understand and intend that this document act as the broadest and most inclusive assumption of risk, waiver, release of liability, agreement not to sue and indemnity.
10. If any provision of this agreement shall be unlawful, void or for any reason unenforceable, then that provision shall be deemed severable from this agreement and shall not affect the validity and enforceability of any remaining provisions.

11. I have fully read and understand this agreement. I am aware that by signing this agreement, I am waiving certain legal rights I or my heirs, next of kin, executors, administrators and assigns may have against the Released Party.
12. I hereby acknowledge that I may be required to use an automobile to travel to and from the Activity or as part of the Activity. I hereby acknowledge that I have the authority to use such automobile and that the automobile is fully insured for use in the Activity. I accept full responsibility for the automobile and that use of the automobile in the Activity will be at my own risk.

13. I agree that by signing into or participating in an online or live activity or other offering, I am agreeing to the terms listed above and accept full responsibility for any injury that occurs during.
14. I agree that by signing into or participating in an online or live activity I will notify my instructor immediately of any pain and/or major discomfort felt during any activity.

15. I agree that by signing into or participating in an online or live activity I am responsible for bringing my required equipment to every activity (where applicable).
16. I agree that by signing into or participating in an online or live activity If I am pregnant I will inform my instructor.