Comprehensive Counseling Services (CCS)

Comprehensive Counseling Services (CCS) provides a range of psychological modalities based on the client's needs. Consumer Care and genuine regard for the individual's well-being is the primary goal of this facility. All meetings are strictly confidential and are instituted under the guidelines of The National Board of Certified Counselors (NBCC), The American Counselor Association (ACA) and The New Jersey Code of Ethics. Client's information can only be shared with others outside the process with the client's expressed permission. The Counselor is prohibited by law to share any of the client's information with anyone. If the client decides to do so, a request must be made in writing and submitted to the Counselor. The only exception is if there are threats being made to one's self or others, in this event the proper law enforcement authorities would be contacted and a complaint could be filed.

Clients are required to be on time for scheduled appointments. In case of an emergency, please call prior to your appointment, at least 24hrs if possible. The first lateness, clients will be given a grace period due to the financial strain of the Covid-19 Pandemic. If a second lateness occurs, this will cause the client to be charged a co-pay payment.

Thanking you in advance for your understanding and cooperating during these difficult times.

CCS PROVIDES OPEN, HONEST, AND RESPECTFUL SERVICES TO OUR CLIENTS

Leonard H. Smith MA, LPC

COMPREHENSIVE COUNSELING SERVICES

License #: 37PC00578700 Phone #: 201- 914- 4106

Client Rights and Confidentiality Statement

Clients / Patients must be informed of their rights and verbal clarification of their rights. Comprehensive Counseling Services (CCS) is responsible for the safety of your records established by the NJ Code of Ethics. CCS has a primary obligation to protect the client's right to confidentiality established by law. Confidential information shall only be revealed to others when the clients or persons legally authorized to give consent on behalf of the clients, have given their informed consent, except in those circumstances in which failure to so would violate other laws or result in clear and present danger to the client or others. Unless specifically contraindicated by such situations, client shall be informed and written consent shall be obtained before the confidential information is revealed. Records must be obtained for a minimum of five years. For minors, the requirement is age of majority plus seven (21).

Client name: _____

Sign:_____ Date :_____

Leonard H. Smith MA. LPC

Comprehensive Counseling Services

Comprehensive Counseling Services uses a third party biller to process all insurance claims. They are a billing company with years of experience however, we at CCS practice full transparency with our clientele. Therefore, we would appreciate your signature of approval by signing this statement of acknowledgment.

I authorized CCS to release the information regarding my assessment.

Thanking you in advance for your cooperation.

Name _____ Date :_____/_____/_____

_____

Leonard H. Smith MA, LPC

Comprehensive

Counseling

Services

Agreement Service Fees:

Patients w/ Medical Insurance- office visits must pay a co-pay upon every visit. Their insurance company will be billed the balance of the total visit. Patient's are responsible for any and all charges not covered by their medical provider.

Patients w/out Medical Insurance- office visits are $90.00 for an individual patient, $135.00 for Couples Counseling and $160.00 for Family Counseling. Payments are due when services are rendered.

Cancellation- patients have 24hrs. prior to a scheduled visit to cancel an appointment. Failure to do so will result in a $25.00 charge to the patient's account.

Authorization to Release Information-

I,_____ hereby, authorize Comprehensive Counseling Services, LLC, to release the information requested from my insurance company for the purpose of processing my claim and/or claims.

☆☆If a patient received a check from the insurance company for services rendered by Comprehensive Counseling Services, LLC, it is the patient's responsibility to submit the check to CCS to pay for visits already made.

Non Payment of fees may result in termination of services

I agree to pay any and all fees due to Comprehensive Counseling Services, LLC, including those uncovered by the patient's medical insurance. Furthermore, I understand this release and financial agreement remain valid until the patient's account is paid in full.

_____ _____

Patient/Parent and/or Guardian. **Date**

Check One: Self:___ Guardian ___ Parent ___ Other ___

_____ _____

Agency Representative **Date**

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $ 0.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN # GRP #

ALIGN BY TYPING AN X IN BOX

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 12/90)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500
APPROVED OMB-0938-0008

CFI # 6