Charis Institute for Psychological and Family Services
21 Southgate Court, Suite 101
Harrisonburg, VA 22801

Phone: 540.568.1876
Fax: 540.574.6076

General Information - Adult

Thank you for choosing Charis Institute. We sincerely hope this will be a place of healing for you. Please take the time to fill out all of these forms and read all of the information regarding your treatment, the payment, and your insurance policy.

When 24-hour notice is not given there will be a charge of $35 for missed appointments.

Where did you hear about our services or who referred you?_____

Client Information

_____ _____/_____/_____ _____-____-_____
Name Date of Birth Social Security Number

_____ (____)_____ (____)_____
Mailing Address Home Phone Cell Phone

_____ _____
City Zip Code Occupation

_____ (____)_____
Employer/School Work Phone

For your comfort and assurance of confidentiality we ask that you please read over the following and sign:

- I give permission for charis institute to call my cell or home and leave a message on the answering maching or with anyone who answers the phone.
- I give permission for charis to call my work number if I need to be reached.

_____ _____
Signature Date

Marital Status: __Single ___Married __Divorced __Separated **If you are married, please state how many years**_____

_____ _____-____-_____ _____ ____/____/____ _____
Spouse's Name Social Security Number Age Date of Birth Employer

If you have children please list (include ages) _____

Person Responsible For Account (If other than the client, by providing this information you are allowing us to release relevant information to this individual, regarding billing)

_____ _____/_____/_____ _____-____-_____
Name Date of Birth Social Security Number

_____ (____)_____ (____)_____
Mailing Address Home Phone Cell Phone

Insurance Information

_____ _____ _____
Insurance Company Policy Number/Member ID Group Number

_____ _____ ____/____/____
Insurance Company Address Name of Cardholder Cardholder DOB

_____
Mailing Address of Cardholder City State Zip

Method of Payment *Please check the method of payment that you will be using.*
Cash Charge Payment Plan Insurance/Co-Pay or Deductible

You should be aware that different insurance companies vary greatly in the types of coverage available. Some insurances require prior authorization for treatment. Prior to your appointment it is your responsibility to contact your insurance to see if authorization is required We ask that you look upon your insurance realistically as a device which helps you pay for your care here at Charis Institute. Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation for the fee for the services rendered is yours. All fees will be due on the day of treatment even if you have insurance unless arrangements are made in advance with our office. Insurance companies typically limit their coverage to services that *they* consider medically necessary. In the event that you receive services and your insurance determines it did not meet their criteria, you understand that you are responsible for payment for these services. I hereby authorize treatment. I authorize Charis Institute to furnish insurance carriers with any medical information necessary to process this claim. I hereby assign to Charis Institute all payments for services rendered to my dependents or myself. I acknowledge that insurance claims pending beyond 60 days are my responsibility and I agree that I will not delay payment and that I will pay the balance if a claim is pending more than 60 days. I understand that if I make a payment and payment is received later by Charis from my insurance company, I will be reimbursed. If a check is returned to Charis Institute, I understand that I will be responsible of paying the fee that bank charges them. I have read and understand the Privacy Policy that is posted is the office.

_____ _____/_____/_____
(Signature/Guarantor) (Date)

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score