

CONCERN® Services
BILLING/CLOSURE FORM

****PLEASE COMPLETE ALL SECTIONS TO AVOID DELAYS IN PAYMENT****

Client Name: _____ Member ID: _____

Make Check Payable to: _____ Tax ID #: _____

Mailing Address: _____

Email Address: _____

List Dates of Service: _____

Total # Sessions Delivered: _____

REFERRAL LOG:

EAP Services Only EAP Counseling & Collateral Referral EAP Assessment/Referral

If Referral, to:

<input type="checkbox"/> CD Counselor	<input type="checkbox"/> Child Care	<input type="checkbox"/> Legal	<input type="checkbox"/> MH Residential
<input type="checkbox"/> CD Day Treatment	<input type="checkbox"/> Counselor/Social Worker	<input type="checkbox"/> Medical	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> CD Inpatient	<input type="checkbox"/> Educational/Vocational	<input type="checkbox"/> MH Day Treatment	<input type="checkbox"/> Psychologist
<input type="checkbox"/> CD Intensive Care	<input type="checkbox"/> Elder Care	<input type="checkbox"/> MH Inpatient	<input type="checkbox"/> Self Help
<input type="checkbox"/> CD Residential	<input type="checkbox"/> Financial	<input type="checkbox"/> MH Intensive Care	

FREEDOM OF CHOICE AFFIDAVIT: If a referral is necessary and client elected to remain with Affiliate therapist utilizing either their insurance or self pay, Affiliate attests that other options were discussed with client including advantages and disadvantages of each option and the costs of each option.

PROBLEM TYPE (Choose one):

CS1 <input type="checkbox"/> Workplace Problem	CS6 <input type="checkbox"/> Other Life Stressors
CS2 <input type="checkbox"/> Family	CS7 <input type="checkbox"/> Relationship/Marital
CS3 <input type="checkbox"/> Health	CS8 <input type="checkbox"/> Traumatic Event
CS4 <input type="checkbox"/> Legal	CS9 <input type="checkbox"/> Substance Abuse/Addiction
CS5 <input type="checkbox"/> Mental/Emotional	

CLINICIAN RATING OF FUNCTIONAL IMPROVEMENT:

(1=Very Serious Problem, 2= Serious Problem, 3=Moderate Problem, 4=Slight Problem, 5=No Problem)

Beginning Rating: 1 2 3 4 5 Closing Rating: 1 2 3 4 5

CLOSING SUMMARY: _____

Do you offer new client appointments after 5:00pm? Yes No

Affiliate Signature: _____ Date: _____

CONCERN TC Signature: _____ **Date:** _____

BILLING DEPARTMENT USE ONLY: Date Posted: _____ Posted By: _____