PREFERRED COUNSELING

CLIENT REGISTRATION FORM

CLIENT

Last Name: _____ First Name:_____ Middle:_____

Gender: M F Date of Birth: _____ / _____ / _____ Age: _____ SS#: _____

Marital Status: (circle one) Single Married Divorced Separated Widowed

Home Address: _____

City: _____ State: _____ Zip: _____

Please circle the phone number(s) below you authorize us to leave voice messages on:

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email: _____ May we email you appointment and office notices? Y N

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

City: _____ State: _____ Zip: _____

SPOUSE OR PARENT/GUARDIAN

Last Name: _____ First Name: _____ Middle: _____
Employer: _____ Occupation: _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Date of Birth: _____ / _____ / _____ SS#: _____

EMERGENCY (Name and phone number of nearest relative or friend not living with you)

Last Name: _____ First Name: _____ Middle: _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Relation to Client: _____

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services.

_____ _____
Signature of client or parent/guardian Date

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

_____ _____
Signature of client or parent/guardian Date

PREFERRED COUNSELING

INSURANCE INFORMATION

Client Last Name: _____ **First Name:** _____ **MI:**_____

INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____ Phone # ( )_____

Primary Insured's Name _ _____ ID/Policy#_____

Primary Insured's Date of Birth _____ Group/Plan# _____

Insurance Company _____ Phone # ( )_____

Primary Insured's Name _ _____ ID/Policy#_____

Primary Insured's Date of Birth _____ Group/Plan# _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____

Relationship to Client _____ SS# _____

Home Address _____ Apt#_ _____

City _____ State_ _____ Zip_____

Home Phone # _____ Work Phone #_____

Employer Name _ _____ Occupation_ _____

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

_____ _____

Signature of client or parent/guardian Date

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

_____ _____

Signature of client or parent/guardian Date

PREFERRED COUNSELING

CLIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

Clients who do not have health insurance:

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their accounts are paid in full on each visit. A written copy of our fee schedule is available upon request.

Clients with a deductible have two options:

1. You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay status.
2. You can pay our Time of Service fees, which are significantly less than our regular fees. However YOU will then be responsible for submitting all services you have paid for to your insurance for reimbursement. We will not be billing on your behalf.

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 90 days old is considered delinquent. Office policy dictates that delinquent accounts may be referred for collection which may include possible blemishes on your credit record. If this happens, an administrative collection fee of $100 (minimum) may be added to your account to cover our costs.

If your insurance denies payment for any reason, we will offer you our time of service discount (our lowest fee schedule) for any outstanding charges that are paid in full within 30 days of notice.

I authorize payment of insurance benefits directly to Preferred Counseling, P.A. I also authorize the provider to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, legal entities, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of responsible party (Client or Parent/Guardian) Date

PREFERRED COUNSELING

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of behavioral health treatments (also known as psychotherapy) and any other associated procedures or therapy requested by the licensed practitioners of this practice.

I understand that in order to help create a therapeutic environment, it is the policy of this office that no cell phone usage is allowed in the counselors' office.

I understand, that psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems I bring forward. There are many different methods your health care provider may use to deal with the problems that I hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on my part. In order for the therapy to be most successful, I will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what I will experience.

At times, video recording of sessions may also occur for the purpose of therapist development and are only, if ever, used for confidential training purposes or certifications. It will be discussed with you beforehand if your video would be used for any such confidential training or certification. If this is a problem or concern for you, please contact your therapist immediately to discuss this.

I understand that my first few sessions will involve an evaluation of my needs. By the end of the evaluation, my health care provider will be able to offer me some first impressions of what work will be included and a treatment plan to follow, if I decide to continue with therapy. I understand that I should evaluate this information along with my own opinions of whether I feel comfortable working with my therapist. Because therapy involves a large commitment of time, money, and energy, I should be very careful about the therapist I select. If I have questions about suggested therapies or procedures, I should discuss them whenever they arise. If my doubts persist, the office or my therapist will be happy to help set up a meeting with another mental health professional for a second opinion.

If there is any dispute about the care I am receiving in the above named office, I agree to a resolution by binding arbitration in accordance to the American Arbitration Association guidelines.

I have read (or have read to me), the above explanation of the psychotherapy treatments. I state that I have been informed and weighted the risks involved at this health care office. I have decided that it is in my best interest to receive psychotherapy treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____	_____	_____
Printed Name of Client	Signature of Client	Date
_____	_____	_____
Signature of Representative (If Client is a minor or is handicapped)	Witness to Client's signature	Date

PREFERRED COUNSELING

ELECTRONIC COMMUNICATION ACKNOWLEDGEMENT

TECHNOLOGY ASSISTED COUNSELING AGREEMENT AND CONSENT

I consent to engaging in Technology Assisted Counseling (TAC). I understand that TAC includes consultation, treatment, and transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that TAC also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to TAC:

1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2) The laws that protect the confidentiality of my medical information also apply to TAC. As such, I understand that the information disclosed by me during the course of therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards and ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3) I understand that there are risks and consequences from TAC, including but not limited to the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4) You are responsible for information security on your computer, tablet, phone, and any other technology device. If you decide to keep copies of our emails/texts or communication on your computer or device, it's up to you to keep that information secure. Security of our emails cannot be guaranteed as they travel between our computers. It is possible, though unlikely, to intercept emails in transit. If you are concerned about that possibility, please consider the option to encrypt our emails. Even if an encrypted email were intercepted, the encoded message would be unreadable. You acknowledge some forms of TAC involve the risk of the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and open to other's intrusion. It is YOUR responsibility to create an environment on your end that is not subject to unexpected or unauthorized intrusion of your personal information. It is MY responsibility for me, the counselor, to do the same.
5) I understand that I may benefit from TAC, but that results cannot be guaranteed or assured.

(For a client who resides outside their counselor's state of residence and professional licensure, there is an important issue that should be understood before TAC begins: By utilizing the therapeutic services, the client agrees that he/she is soliciting the services of a professional outside of his/her state of residence. By doing this, the client agrees that the "point-of-service" of the counseling is to occur in the counselor's state of residence and licensure, not the client's. In essence, the client is using the telephone or Internet to virtually travel to the counselor (the counselor's state of professional practice). Hence, counselors are accountable to and agree to abide by the ethical and legal guidelines prescribed by their state of licensure and residence. By agreeing to solicit the counselor's services, the client agrees to these terms.)

I have read and understand the information provided above. I have discussed with my counselor questions and concerns I have, if any, and all have been answered to my satisfaction.

_____ _____

Signature of Client Date

_____ _____

Witness to Signature Date

PREFERRED
COUNSELING

Appointment Reminders and Communication Authorization

You can receive an appointment reminder to your email address, your cell phone (via text message), or your home phone (via a voice message) the day before your scheduled appointments.

Your name: _____

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

Where would you like to receive reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

I understand there may be circumstances where my therapist or Preferred Counseling will need to communicate with me outside of scheduled appointments, such as in the event of inclement weather or the need to reschedule an appointment. In such cases, I authorize Preferred Counseling to contact me at any of the above listed phone numbers or email address.

_____ _____

Signature Date