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: _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Employer: _____ Occupation: _____
Email address: _____

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: _____

INSURANCE We need a copy of your card(s) for our records. **PRIMARY and/or SECONDARY MUST BE INCLUDED!**

Primary Insurance Company _____ Phone # ( )_____
Primary Insured's Name _ _____ ID/Policy#_____
Primary Insured's Date of Birth _____ Group/Plan# _____

Secondary Insurance Company_____ Phone # ( )_____
Primary Insured's Name _ _____ ID/Policy#_____
Primary Insured's Date of Birth _____ Group/Plan# _____

Are we billing an EAP company for your visits? _____ If yes, Name of Company _____
Are we billing Worker's Compensation? _____ If yes, Name of Company _____

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 #_____

MY CERTIFICATION

I certify that the above information is correct and I request services. I certify that the signature below is a true and accurate representation of my signature.

I elect to receive any billing statements via (please check one): EMAIL: _____ or MAILED: _____

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; obtain payment from third-party payors; conduct normal healthcare operations such as quality assessments and accreditation, state and federal mandated requirements, court ordered or AR Board of Examiners in Counseling regulatory activities. **I consent to the release of ALL information to facilitate medical records reviews by those contracted by my insurance company.**

_____ _____
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 EAP or insurance carrier. You are also responsible for any charges incurred should you request any letter, documentation or court requested information from your therapist regarding your treatment. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

IT IS THE CLIENT'S RESPONSIBILITY TO ADVISE PREFERRED COUNSELING OF ANY EAP OR INSURANCE THAT IS IN EFFECT AT THE TIME OF THE APPOINTMENT. WE DO NOT BACK BILL THE EAP OR INSURANCE FOR PAST VISITS.

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 three options:

1. You may pay our regular fee schedule and we will bill the insurance company 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/coinsurance status, however, it is the clients responsibility to notify PC when the insurance status has changed.
2. You may pay our Time of Service if you have no insurance or your insurance is out of network with Preferred Counseling.
3. You may file with your insurance on your own if we are out of network.

We 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. An administrative collection fee of $100.00 (minimum) may be added to your account to cover our costs.

If your insurance denies payment for any reason, please make contact with our office to make payment arrangements. Any outstanding charges are to be paid in full within 30 days of notice.

If you sign a waiver regarding the filing of your insurance, we cannot at a later date bill the insurance for previous appointments.

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.*

Please check your preferred method of billing: Receive my statements via either email. _____ or postal service _____ .

If I have Medicare or any other insurance, and Preferred Counseling is out of network or cannot file with them, I agree to pay whatever charges that would normally be billed. I have been made aware of the insurance companies with which Preferred Counseling is in network and is able to file.
By signing below, I indicate that I have read, understand, and agree with the terms on this page. I also give consent to send auditors or insurers records regarding payment and compliance for yearly review.

******$95.00 fee for NO SHOW or CANCELLATION LESS THAN 24 HOURS may be charged to my account******

Quote Disclaimer

The information being provided to you is our best estimate for your portion of the fees for services received at our office. This estimate is provided to you as a courtesy and is based upon current information received from your insurance company and in some cases, historical data in our system. Therefore, all benefits information quoted and estimates given are not guaranteed. You may contact your insurance company directly for questions and complete information regarding your mental health coverage and benefits.

_____ _____

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), EMDR, and any other associated services, including face-to-face, or technology based via telephone, or computer audio and video, etc.

Due to the possibility of a confidentiality breach (HIPAA), I understand and acknowledge the policy of this office is: *ALL CELL PHONES MUST BE TURNED OFF* UPON ENTERING THE BUILDING.

I UNDERSTAND THAT, FOR THE SAFETY OF ALL, CHILDREN UNDER THE AGE OF 12 MUST BE ACCOMPANIED BY AND MONITORED BY A RESPONSIBLE PERSON (GENERALLY AN ADULT 18 OR OLDER) WHILE THEY ARE IN THE WAITING ROOM. I, AS THE ADULT IN CHARGE OF BRINGING CHILDREN TO THE OFFICE, WILL ASSUME ALL RESPONSIBILITY FOR THEIR WELFARE AND ASSUME FULL RESPONSIBILITY FOR ANY DAMAGES THEY MAY CAUSE IN THE WAITING ROOM.

I understand, that psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient and the particular problems I bring forward. There are many different methods my 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. NO session may be taped or recorded without the acknowledgement and permission of both the client and therapist. Also, NO session or portion of a session may be posted or used for any type of social media or network.

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 therapy will be included and a treatment plan to follow that is best for me. I understand that I should evaluate this information along with my own opinions of whether I feel comfortable working with my therapist if I decide to continue with therapy. 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.

I understand that my records will be kept confidential according to HIPAA guidelines. PC therapists carry liability insurance and practices under his/her board-certified scope of practice. If I need further information regarding my therapist, I can refer to the Preferred Counseling website or request the information from my therapist.

Social Media Policy

Therapists may maintain professional and personal presences on social media. They do not accept friend, fan, or contact requests from current or former clients on any social networking site (Facebook, Linkedin, etc.). This protects the privacy of the therapist-client relationship. Therapists do not follow clients on social media, nor do they view a client's information on social media unless given consent. As a client, we ask that you do not contact your therapist via text message or messaging on social networking sites. Also, most of these sites are not secure. Your therapist must have special certification for technology conversations. If you need to contact your therapist between sessions, please call our office.

I understand that I may, via written request, have access to my medical records at any time. If the records are a joint/marital file**, both parties must sign** a release form for counseling in order to obtain copies of the records. If the client is under the age of 18, the legal guardian or if there is joint custody of the child, then both parents need to sign a release. Preferred Counseling requires a minimum of 7-10 business days to process any written medical records releases. Records requests are subject to an administrative fee.

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.

I understand that in the unlikely event that my therapist is unable to provide ongoing counseling services, Preferred Counseling may provide or refer me to the appropriate therapeutic resource or counselor. PC will have access to and maintain my records for the required seven (7) to ten (10) years. Please contact Preferred Counseling's business manager at 479-709-9880 if you have further questions.

Initials: _____ All of my questions were addressed by the front staff. 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

Medical/Mental Health Treatment Summary

Client Name: _____

Client Allergies or Adverse Drug Reactions: _____

Primary Care Physician: _____ Other Physicians You See_____

Current Prescription Medications:

Start Date	End Date	Medication	Dosage	Reason for Use	Doctor

Over-the-Counter Medications/Herbs/Vitamins:

Start Date	End Date	Medication	Dosage	Reason for Use

Hospitalizations/Surgeries:

_____

Mental Health Diagnosis:

Authorization to Disclose Protected Health Information to Primary Care Physician and/or Psychiatrist

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) and/or Psychiatrist is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP and/or Psychiatrist. This Information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication record if necessary.

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

- □ I agree to release any applicable mental health/substance abuse information to my PCP:
  Primary Care Physician _____Phone_____
  Address _____
- □ I agree to release only mediation information to my PCP.
- □ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to notify him/her.
- □ I agree to release any applicable mental health/substance abuse information to my psychiatrist:
  Psychiatrist _____Phone_____
  Address _____
- □ I agree to release only mediation information to my psychiatrist.
- □ I WAIVE NOTIFICATION of my psychiatrist that I am seeking or receiving mental health services, and I direct you NOT to notify him/her.
- □ I do not have a PCP/Psychiatrist and do not wish to see or confer with one.

Signature:_____. Print Name:_____ Date:_____

PREFERRED COUNSELING

GENERAL INFORMATION RELEASE AND CRISIS CONTACTS

Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____ DOB_____

I give permission to Preferred Counseling to discuss the following information about me VERBALLY OR VIA EMAIL (check all boxes that apply)

- □ *Scheduling / Appointment information*
- □ *Coordination of Services*
- □ *Billing and payment information*
- □ *If in crisis, my Crisis Contact(s):*

Preferred Counseling has my permission to discuss the above information with:

Name	*Phone*	*Relationship to Client*

I understand that I may cancel this permission at any time (in writing), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want PC to share my information with the person(s) listed above.

I understand that this form does not give the above referenced persons permission to make health care decisions for me or entitle them to paper or electronic copies of my medical record.

This authorization expires:

- □ When I cancel it in writing OR

- □ _____ (specify Date), If no date specified this authorization will remain in effect until PC receives written notice to cancel it.

_____ _____

Signature of Patient / Guardian Date

PREFERRED COUNSELING

TECHNOLOGY ASSISTED COUNSELING INFORMED CONSENT

I am giving my: **(please circle one)** ***verbal*** and/or ***written*** 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) Therapist will take steps to verify the clients' identity at the beginning of the therapeutic process. 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 an ascertainable victim(s); and where I make my mental or emotional state an issue in a legal proceeding. When distance counseling services are deemed ineffective by the counselor, or client, counselors consider delivering services face-to-face, or may deem this application is not appropriate for the needs of the client.

3) I understand that there are risks and consequences from TA. Considerations will be made at the time of the appointment for time zone differences, cultural and/or language differences that may affect delivery of services. This also includes (but is 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. Our office uses an encryption system for video and data, (i.e., emails and texts). In the possibility of technological failures, alternate methods of service delivery will be discussed by your therapist. If you cannot make immediate contact due to technological failure, the therapist and/or office will contact you within 24 – 48 hours.

4) Just as the therapist is responsible for security on his/her system, 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, if unencrypted 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. Counselors will use current encryption standards within their websites and/or technology-based communications that meet all applicable requirements.

5) I understand that I may benefit from TAC, but that results cannot be guaranteed or assured.

6) Video counseling sessions will NOT be recorded without prior knowledge and consent of BOTH the therapist and client and then, only for a specific purpose. Records of sessions will be kept in a secure electronic file the same as face to face sessions.

7) Social Media Policy: Therapists may maintain professional and personal presences on social media. Counselors understand the necessity of establishing boundaries regarding the appropriate use or application of technology. They do NOT accept friend, fan, or contact requests from current or former clients on any social networking site (Facebook, Linkedin, etc.). This protects the privacy of the therapist-client relationship. Therapists do not follow clients on social media, nor do they view a client's information on social media unless given consent. As a client, we ask that you do not contact your therapist via text message or messaging on social networking sites. Also, most of these sites are not secure. Your therapist must have special certification for technology conversations, except in crisis situations deemed by the Governor of Arkansas or the President of the United States. If you need to contact your therapist between sessions, please call our office.

8) If my counselor is not immediately available, and I am in crisis, I WILL do as recommended and contact a crisis line or local agency or emergency room. Clients may utilize the following crisis hotlines:
1-800-SUICIDE (800-784-2433)/ 1-800-273-TALK (800-273-8255) /For the Deaf: 1-800-799-4TTY (800-799-4889).

These are my LOCAL Crisis contact numbers that I am making available to my therapist:

Name of local Hospital: _____

Name of local Law Enforcement: _____

Name of local Medical Clinics: _____

I do not wish to do Telehealth during inclement weather:

_____
Client Signature

(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 clients. 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.

_____ _____
Printed name of client Date

_____ _____
Signature of client Date

_____ _____
Witness to signature Date