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: _____

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 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.

_____ _____
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; 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

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 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 status.
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 your insurance on your own if we are out of network with your insurance company.

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. 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, 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.
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 they 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.

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) 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 counselor's office and especially video of any type in the office lobby area, (HIPAA regulations).

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 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. NO session maybe taped or recorded without the acknowledgement and permission of both the client and therapist. Also, NO session or portion of a session maybe 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 work 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 I may request access to my medical records at any time. Preferred Counseling requires approximately 7 days to process medical records releases.

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, the business manager of Preferred Counseling will provide those services or refer me to the appropriate therapeutic resource or counselor. They will have access to and maintain my records for the required ten (10) years. Please contact Preferred Counseling's business manager at 479-709-9880 if you have further questions. **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

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:

Signature of Client and Legal Representative: _____

PREFERRED COUNSELING

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. 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.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature (if under 18) Witness

Patient Rights:

· You can end this authorization (permission to use or disclose information) at any time by contacting our office.
· If you make a request to end this authorization, it will not include information that has already been used or disclosed on your previous permission.
· You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
· You have a right to a copy of this signed authorization. Please keep a copy for your records.
· You do not have to agree to this request to use or disclose information.

Information to be completed by Behavioral Health Provider:

I saw _____ on _____ for _____
(Patient Name) (Date) (Reason/Diagnosis)

Summary: _____

_____

_____

_____ _____
Therapist Signature Date

PREFERRED COUNSELING

Appointment Reminders and Communication Authorization

As a courtesy, you can receive an appointment reminder to your email address two days before your scheduled appointment. However, **it is your responsibility** to keep up with your appointment times. If you need to cancel or change an appointment, please do not reply to the email. Appointment changes **MUST** be made by phone through our office. Cancellations less than 24 hours in advance may be subject to a $95.00 charge, as stated in our office policies.

Your name: _____

Your email address: _____

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, the need to reschedule an appointment or for billing and insurance purposes. In such cases, I authorize Preferred Counseling to contact me at any of the above listed email address.

--or—

_____ I waive notification of my appointments by email. It is my responsibility to keep up with my appointments.

_____ _____

Signature Date

PREFERRED COUNSELING

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*
- □ *Billing and payment information*

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.

This authorization expires:

- □ When I cancel it in writing

- □ _____ (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