CLIENT REGISTRATION

PLEASE PRINT INFORMATION CLEARLY – ONE CLIENT PER FORM PLEASE

➢**NAME:** _____ ➢**DATE OF BIRTH**: _____

SOCIAL SECURITY #: _____ ➢**GENDER**: _____ ➢**AGE:** _____

MARITAL STATUS : ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

➢**MAILING ADDRESS**: _____
(STREET/APT.) *CITY* *STATE/ZIP*

TELEPHONE: 1) _____ 2) _____ 3) _____
{CIRCLE TYPE} : *(HOME CELL WORK)* *(HOME CELL WORK)* *(HOME CELL WORK)*

EMAIL: _____ PARENTS/CAREGIVERS: _____

EMERGENCY CONTACT: _____
NAME *PHONE* *RELATIONSHIP*

WHO REFERRED YOU TO THIS OFFICE? _____ PCP: _____

PCP ADDRESS/PHONE: _____

➢ **PRIMARY INSURANCE CARRIER**: _____ ➢**THERAPY IN PAST 12 MONTHS?** ☐ YES ☐ NO

➢**MEMBER ID #:** _____ COPAY/DEDUCTIBLE: _____

➢**IS THE PATIENT THE INSURANCE POLICY HOLDER?** ☐ YES ☐ NO ✧IF **NO,** THIS INFORMATION IS REQUIRED:

✧POLICY HOLDER'S NAME: _____ ✧DATE OF BIRTH: _____

✧RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY #: _____

✦*EAP: AUTHORIZATION #:* _____ ✦*START DATE:* _____ ✦*# SESSIONS:* _____ ✦*END DATE:* _____

✦ *EAP/ SECONDARY INSURANCE CARRIER NAME:* _____ *THE FOLLOWING IS REQUIRED FOR BOTH EAP & SECONDARY:*

✦*MEMBER ID #:* _____ ✦ *PATIENT POLICY HOLDER? ☐YES ☐NO* ✧*IF NO, THIS INFO IS REQUIRED:*

✧*POLICY HOLDER'S NAME:* _____ ✧*DATE OF BIRTH:* _____

✧*RELATIONSHIP TO PATIENT:* _____ *SOCIAL SECURITY #:* _____

Federal regulations allow me and/or my Billing office to use or disclose protected Health Information from your record to provide treatment, obtain payment for the services I provide, and operate my practice. Nevertheless, I ask your consent in order to make your permission explicit. My Notice of Privacy Practices describes these disclosures in greater detail which you have the right to review before signing this consent.

I hereby authorize the provider of service to furnish information requested by my Insurance Carrier and I hereby assign to the provider all payments rendered to myself or my dependents. I understand it is my responsibility to pay for any deductible amount, co-payment, or other allowable balance not paid by the insurance.

➢ **DATE**: _____ ➢ **SIGNATURE**: _____

CLINICIAN USE ONLY:

➢ THERAPIST: _____ TX: _____ OCR: ☐ YES ☐ NO

➢ INTAKE DATE: _____ ➢ DX: 1ST _____ 2ND _____ 3RD _____ 4TH _____

SELF PAY RATE: _____ _____ _____ _____ _____

Late Cancellation & Missed Appointment Policy

Once you schedule an appointment with me, that time is reserved exclusively for you. In order to successfully operate my practice, I need to be able to rely on these therapy appointments. Therefore, I have established the following policy for missed and canceled appointments.

For any appointment that is missed or canceled with less than the required 24 hour notice, no matter what the reason, clients will be charged the fee that I would have billed for that session, as shown below. Also, keep in mind that missed or late canceled appointments are not covered by your health plan and cannot be billed to your insurance company.

Initial Evaluation $200	Family Consults $120	Phone calls 10 minutes or more $130 hour, prorated
Individual Therapy 60 Minutes $150	Individual Therapy 45 Minutes $130	Legal reports $200/hour
Couple or Family Therapy $175	Individual Therapy 30 minutes $100	Court appearances $250/ hour plus expenses, 4 hour minimum paid in advance
Group Therapy $50		

I realize that on infrequent or rare occasions an event may occur in your life that requires the canceling of your scheduled appointment with less than the required 24 hours. Such cancellations may be the result of a sudden illness in yourself or family member, the untimely breakdown of your automobile or an employer requiring you to stay late at the office. I will do my best to offer you a timely rescheduling of your appointment. Nevertheless, keep in mind that regardless of the understandable reason for cancelation, you will still be charged for the time I have reserved for you.

The only exception to this policy is for cancellation in severe weather. If the driving conditions are such that you do not feel safe driving to my office, please call me as soon as possible. If you call me and we confirm your cancellation due to inclement weather, the cancellation fee will be waived. If you do not call, regardless of weather conditions, you will still be charged.

We have tried to make this information clear and understandable. Should you have any additional questions, please discuss them with me.

I have been informed of the policies and procedures at Harborside Counseling Services.

*Signature:_____ Date:_____

Welcome to my office. I am pleased to have the opportunity to work with you. I hope this handout will provide helpful information about my services. If you have any questions or concerns, I would like to discuss them with you.

IN CASE OF EMERGENCY

In psychiatric emergencies, please attempt to contact me directly at my office. I check for messages frequently. In extreme emergencies, go directly to your local hospital's emergency room. When I am on vacation, I will give you the name of a colleague covering my practice.

BILLING AND PAYMENT OF FEES

Payment is expected at the time of your appointment unless other arrangements have been discussed and agreed upon in advance. Your health insurance company may reimburse me for your psychotherapy. However, you are responsible for any deductible, co-payment or balance applicable to your individual policy.

INDEPENDENT PRACTICE

I am a psychotherapist in independent practice. I am the sole professional responsible for my treatment with you. No person or organization has clinical responsibility for my work with you.

CLIENT RECORDS AND CONFIDENTIALITY

Clients are assured of confidentiality, which is protected by ethical practice and law. In general, the law states that all communication between a licensed practitioner and his/her client are confidential. Any information shared will require your signed consent except where disclosure is required by law. Some legal exceptions to maintaining confidentiality are:

- Federal regulations allow me to disclose necessary data from your record in order to obtain payment from your insurance company
- If I have reason to suspect a child or elderly person is being abused or neglected.
- In circumstances in which, to the best of my professional judgment, I believe that you may be a danger to yourself or another.
- If your own mental or emotional health an issue in a court case.
- If your account is overdue and arrangements for payment have not been negotiated, a collection agency will be provided with dates of service, type of service provided and a total amount due.

Name & Address

_____ Primary Care Physician
_____ Organization
_____ Address
_____ City, State Zip

Primary Care Physician Communication Form

I, _____ authorize _____
PRINT CLIENT'S NAME DATE OF BIRTH THERAPIST

to release to my Primary Care Physician as described below:

Please check: ☐ only the information on this page
☐ no information

I understand that this authorization is voluntary and that I have the right to refuse to disclose this information. I understand that my healthcare and payment of my healthcare will not be affected by this form.

_____ _____
SIGNATURE OF CLIENT OR GUARDIAN DATE

OFFICE USE:

Date treatment initiated: _____

Provisional Diagnosis: _____

_____

Provider name: _____ Phone number _____

Initial Treatment Plan:
Type of treatment _____ Frequency _____

Prohibition on Redisclosure

To persons receiving released information: This information has been disclosed to you from records protected by federal regulation which prevents you from making any further disclosures without specific written consent of the person to whom it pertains.

HIPAA Patient Privacy Acknowledgement Statement

I have been given the opportunity to read and ask questions regarding the HIPAA Privacy Notice. I understand that every effort will be made to protect my private information.

*Patient Name: (*print)*_____ *Date of Birth:_____

* Patient Signature_____ *Date:_____