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New Client Registration Packet

Personal Information

Please bring a valid driver's license or identification card. We will need a copy for our records.

Name: _____ DOB: _____ SS#: _____

Address: _____ _____ _____

Home Phone Number: _____ Cell Phone Number: _____

E-mail Address: _____ Age: _____ Race: _____ Gender: Male ___ Female ___

Employer: _____ Occupation: _____

Insurance Information

Please bring your insurance card. We will need a copy for our records.

Health Insurance Provider: _____ Copayment Amount: _____

Plan Name: _____ Plan Group Number: _____

Effective (Start) Date of Policy: _____ Effective (End) Date of Policy: _____

Insurance ID/Member ID: _____ Policy Holder: _____

Address of Policy Holder: _____ _____ _____

Policy Holder DOB: _____ Relationship to Client: _____

Employer of the Policy Holder: _____

Employer Address: _____ _____ _____

Employer Phone Number: _____

Emergency Contact Information

Name: _____ Relationship to Client: _____
Address: _____ _____ _____
Home Phone Number: _____ Cell Phone Number: _____
E-mail Address: _____
Reason for Visit:
_____
_____

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Medical History:

Have you received mental health counseling or been hospitalized *within the last 12 months?* Yes _____ No_____

If yes, list reason for treatment: _____

_____

_____

Previous Medical Providers:

Previous Psychiatrist Name: _____

Previous Psychiatrist Phone Number: _____

Previous Primary Care Physician Name: _____

Previous Primary Care Physician Phone Number: _____

Previous Nutritionist Name: _____

Previous Nutritionist Phone Number: _____

Previous Psychotherapist Name: _____

Previous Psychotherapist Phone Number: _____

Current Medical Providers:

Psychiatrist Name: _____

Psychiatrist Phone Number: _____

Primary Care Physician Name: _____

Primary Care Physician Phone Number: _____

Nutritionist Name: _____

Nutritionist Phone Number: _____

Psychotherapist Name: _____

Psychotherapist Phone Number:_____

Date of Last Physical Exam: _____ Allergies: _____

Medical Conditions: _____

_____

_____

_____

Current Medications (Please include prescribed dosage): _____

_____

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Medical History (continued):

Past Medications (Please include prescribed dosage):_____

_____

_____

Pharmacy Name: _____Pharmacy Location:_____

Pharmacy Contact Number: _____

Please list all surgeries including the year surgery was performed:

_____

_____

_____

Please list medical and psychiatric illnesses in your family.

Relationship to Client: _____ Medical/Psychiatric Illness: _____

Relationship to Client: _____ Medical/Psychiatric Illness: _____

Relationship to Client: _____ Medical/Psychiatric Illness: _____

Relationship to Client: _____ Medical/Psychiatric Illness: _____

Relationship to Client: _____ Medical/Psychiatric Illness: _____

Do you drink alcohol? Yes _____ No_____ If yes, how often_____

Do you smoke tobacco? Yes _____ No_____ If yes, how often_____

Do you use recreational drugs? Yes _____ No_____ If yes, what type and how often_____

Have you ever been treated for substance abuse or dependency? Yes _____ No_____ If yes, list substance and treatment details: _____

_____

_____

_____

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Getting to Know You: Client Questionnaire

1. Do you feel depressed? Yes _____ No_____

2. Are you experiencing changes in your sleep? Yes __ (how) _____ No__

3. Are you experiencing changes in your appetite or eating habits? Yes _ (how)_____No__

4. Are you self-critical? Yes _____ No_____

5. Do you have thoughts of death or suicide? Yes _____ No_____

6. Do you cry frequently? Yes _____ No_____

7. Are you having difficulty concentrating or remembering things? Yes _____ No_____

8. Do you feel tired or withdrawn? Yes _____ No_____

9. Have you lost interest in usually enjoyable activities? Yes _____ No_____

10. Have you ever experienced a period of unusually elevated or extremely irritable mood? Yes _____ No_____

11. Have you ever experienced decreased need for sleep? Yes _____ No_____

12. Do you worry excessively? Yes _____ No_____

13. Do you ruminate or obsess over certain ideas? Yes _____ No_____

14. Do you feel the urge to do things to relieve your anxiety? Yes _____ No_____

15. Do you have sleep disturbance? Yes _____ No_____

16. 16. Do you have muscle tension? Yes _____ No_____

17. Do you have difficulty focusing? Yes _____ No_____

18. Do you experience nightmares? Yes _____ No_____

19. Do you often feel irritable or overwhelmed? Yes _____ No_____

20. Do you ever have experiences that seem bizarre or unreal? Yes _____ No_____

21. Do you experience things that others around you do not? Yes _____ No_____

22. Have you ever attempted suicide? Yes _____ When _____No_____

23. Do you have difficulty with losing your place in conversation? Yes _____ No_____

24. Do you have trouble focusing while reading or working? Yes _____ No_____

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25. Do you act impulsively or speak out of turn? Yes _____ No_____

26. Do you struggle with lack of organization? Yes _____ No_____

27. Do you have difficulty completing tasks or with procrastination? Yes _____ No_____

28. Do you consume far fewer calories than what you consider to be adequate? Yes _____ No_____

29. Are you concerned about your weight? Yes _____ No_____

30. Do you ever induce vomiting or use laxatives due to concern about your weight? Yes _____ No_____

31. Do you have difficulty in relationships? Yes _____ No_____

32. Do you struggle with intense emotions? Yes _____ No_____

33. Do you think you perceive things differently than most other people? Yes _____ No_____

34. Are you easily frustrated? Yes _____ No_____

35. Do you ever hurt yourself intentionally? Yes _____ No_____

36. Do you use any drugs? Yes _____ No_____

37. Do you drink alcohol? (if no, then skip questions 39-42) Yes _____ No_____

38. Do you feel the need to reduce your alcohol intake? Yes _____ No_____

39. Do you feel guilty about your alcohol consumption? Yes _____ No_____

40. Do you ever feel annoyed by others' comments about your drinking? Yes _____ No_____

41. Do you ever need alcohol first thing in the morning? Yes _____ No_____

42. Do you often eat too much or too quickly or feel out of control when eating? Yes _____ No_____

43. Do you have thoughts of death or dying? Yes _____ No_____

44. Are you married? _____ Yes _____ No_____

Name of spouse, if married _____

45. Do you have children Yes _____ No_____

Name(s) of child(ren): _____

46. Last grade completed: _____

47. What is your sexual orientation: _____

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Financial Agreement

Thank you for choosing establisHER: Counseling & Life Solutions, PLLC for your mental health care. Please understand that payment of your bill is considered part of your treatment. A breach in payments or repeated cancellation of appointments can result in administrative discharge from establisHER: Counseling & Life Solutions, PLLC.

Full payment is due at the time of service. Cash, credit cards, debit cards and payments submitted via CashApp or PayPal are accepted. Payments plans and sliding scale fees can be discussed in cases of financial hardship. You are responsible for full payment of your session fee, copay, late fees and past due balances at the time of service unless other arrangements have been discussed prior to the session.

establisHER: Counseling & Life Solutions is committed to providing the best treatment for all clients and we charge the usual and customary rate for our area. If I am not credentialed with your insurance company submission for reimbursement from your insurance company, it will be your responsibility to submit a superbill for your reimbursement. A receipt of payment will be provided. I encourage you to call your provider to inquire about your in network and out of network benefits. If you fail to maintain insurance coverage or your insurance company denies your claims, you will be held financially responsible for full payment of services provided.

A **cancellation fee** is charged unless your session is cancelled at least **24 hours** in advance. It is our policy to charge a rate of **$75** for the missed appointment. Reminder calls and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.

Please indicate how you plan to pay for co-pays/services:

___ Money Order ___Cashier's Check___CashApp ___PayPal __Credit Card Payment ___Cash

This section must be completed by the Authorized User of this Credit Card

If you selected the Credit Card option, please provide the following information:

Name as it appears on Credit Card: _____

Credit Card Statement Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Type of Credit Card: ____ MasterCard ____ Visa ____ American Express ____ Discover

Credit Card Number: _____ **Exp. Date:** _____ **CVV Code (3 digit code on back of card):** _____

By signing this section of the financial agreement, I authorize establisHER: Counseling & Life Solutions to charge any past due balances on my account to the to the credit or debit card listed above.

Printed Name of Authorized User: _____

Signature of Authorized User: _____ **Date:** _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways.

If you do not consent and sign this form, we cannot treat you.

If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

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Notice of Privacy Practices

I, _____, have received a copy of establisHER: Counseling & Life Solutions, PLLC Notice of Privacy Practices.

_____ _____

Signature of Client (or Guardian clients under 18 years old Date

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Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks :

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients. The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand the meanings and ramifications of this agreement.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

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Cancellation Policy

If you are unable to attend an appointment, we request that you provide at **least 24 hours advanced notice** to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be billed directly for the full session fee using the card on file.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date