CLIENT REGISTRATION FORM

Client's Name _____ DOB_____ Age _____

Address_____ City_____ ST_____ Zip_____

Phone: Cell_____ Work _____

Email _____ Parent/Guardian Name _____

(If client is a child/teen, please list parent name, phone numbers, & email)

Emergency Contacts:

(1) Name _____ Number_____

(2) Name_____ Number_____

PERSON RESPONSIBLE FOR PAYMENT

Guarantor's Name _____ DOB _____Cell _____

Address _____)_____City_____ST_____Zip_____

INSURANCE INFORMATION

Check if you are self-pay, if so you do not have to fill out this portion. _____

Primary Insurance Company: _____

Member ID: _____ Group Number: _____

Subscriber Name: _____ Relationship to Client: _____

Subscriber DOB: _____ Subscriber Cell: _____

Subscriber Address: _____

Authorization for treatment; release of information and assignment of insurance benefits:

I authorize **mindCARES**, to furnish individual/family therapy and medical records by necessary means in the treatment of the client identified below, while client is under her care. Records and information are confidential and can be released only with a client's signed release a properly executed subpoena or when the therapists suspect planned or accomplished harm to self or others or suspected or reported child and/or elder abuse. Noncustodial and custodial parents may see their minor child's record unless it would be damaging to the minor. I request the payment of authorized third party payments be made to Suzanne B. Russell, LPC, and If assignment is accepted, in which case I AGREE TO PAY ANY DEDUCTIBLE, CO-PAYMENT, OR CHARGES NOT COVERED BY THIS AUTHORIZATION. I authorize **mindCARE**S to release to any third party insurance any information needed to determine these benefits. For services rendered to the client named below, I, the undersigned, agree to pay all professional and outpatient visit charges not covered by insurance. I also agree to pay reasonable attorney or collection agency fees necessary for the collection of payment. The terms of this Consent for Treatment shall be valid until either party gives written notice of its termination. (A copy of this assignment is as valid as the original.)

CLIENT/ PARENT NAME_____ Date_____

CLIENT/PARENT SIGNATURE _____Date_____

mindCARES Treatment Policy

- At your Intake appointment, we ask you to place a credit card number on file. This is so that if in the event we do not receive 24 hours' notice of canceling or rescheduling your appointment, you will be charged a **$150.00** fee.
- After **3** cancellations of your appointment we will have to refer you to another therapist outside of our office.
- In order to assist you in keeping your appointment, we will give you a courtesy reminder text 24 hours in advance. Please **REPLY** to the text, so that we can ensure proper canceling/rescheduling if needed and you will not be charged.
- A child/teen MUST be accompanied by a parent or legal guardian at every session. **NO EXCEPTIONS!** Your involvement in his/her treatment is essential!
- Please be aware that payment is due at time of service. We **CANNOT** bill copays or deductibles. We take payment by cash or all major credit/debit cards, we cannot accept checks.
- Any time during treatment, if you apply for disability/FMLA and need the paperwork completed, there will be a **$50.00** charge for this service. This fee must be paid in advance and is not covered by insurance.
- If the purpose of the Intake is to determine whether your child has ADHD, the Conners Rating Scale will be used. There is a **$10.00** charge that is due at the time the Conners is given to the parent/guardian. This is not a billable charge on any insurance plan.
- **This office does not handle CUSTODY/COURT ORDERED ISSUES/ALIENATION OF AFFECTION cases.**

I understand all areas on this treatment policy and that my credit card will be charged in accordance with this policy. *****Client initials_____

CLIENT NAME_____DATE_____

CLIENT/PARENTSIGNATURE_____

_____ **VISA| MASTERCARD| AMERICAN EXPRESS| DISCOVER**

Name on card

_ _ _ _-_ _ _ _-_ _ _ _-_ _ _ _ __/__ ____

CC NUMBER **EXPIRATION DATE** **CODE**

Thank you for your cooperation!

Suzanne B. Russell, LPC | Anne Sinclair, LPC | Leigh Ann Germany, LPC | Edwina Thomas, LPC

Notice of Health Information and Privacy Practices (HIPAA)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your health record/information:
Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, and treatment plans. This information is often referred to as your health or medical record and it can serve as:

- Basis for planning your care and treatment
- Means of communication among the many health professions who contribute to your care
- Legal documentation of the care you received
- Means by which your third-party payer can verify services rendered to contribute to your care
- A tool in education to healthcare professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of facility planning and marketing
- A tool with which we can assess and continually work to improve healthcare

Understanding what is your record and how your health information is used to help you:

- Ensure its accuracy
- Better understand who, what, when, where, and why other may access your health information
- Make more informed decisions when authorizing disclosure to others

Although your health record is the physical property of the healthcare facility that compiled it, the information belongs to you. You do have the right to:

- Request a restriction on certain uses and disclosure of your information as provided by 45 CFR 164, 522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164, 528
- Amend your health record as provided in 45, CFR 164, 528
- Obtain an accounting of disclosures of your health information as provided in CFR 164, 528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your consent to use of disclosing health information except to the extent that action has already been taken

All healthcare providers are required to:

- Maintain the privacy of your health information
- Provide you with a notice as our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

You reserve the right to inquire any changes made to this practice's privacy policies at any time. You may contact the office at any time with questions or concerns about your health information privacy.
Examples of disclosures for treatment, payment, and health operations:

- Your healthcare information may be sent to other healthcare providers in order to help with further treatment you may receive beyond our practice.
- Your healthcare information can be used for payment. If we file to your medical insurance company, they may request a copy of your medical record before they reimburse us.
- Your healthcare information can be used for the following: research, communication with family members, funeral directors, marketing, FDA, worker's compensation, correctional institutions, legal processes, and law enforcement.

*We are required by law to release records in response to any legal proceedings such as a subpoena for court. *

Please sign and date signifying that you have read and understand the privacy policy for mindCARES.

_____ _____

Client/ Parent Signature **Date**

USE OF INSURANCE AT MINDCARES

I AUTHORIZE mindCARES TO RELEASE TO ANY THIRD PARTY INSURANCE ANY INFORMATION NEEDED TO DETERMINE BENEFITS. FOR SERVICES RENDERED, I THE UNDERSIGNED AGREE TO PAY ALL PROFESSTIONAL AND OUTPATIENT SESSIONS CHARGES NOT COVERED BY INSURANCE. I ALSO AGREE TO PAY COLLECTION AGENCY CHARGES FOR THE COLLECTION OF THIS PAYMENT, IF PAYMENT IS NOT RECEIVED BY THIS OFFICE.

CLEINT/ PARENT NAME _____ DATE _____

CLIENT/ PARENT SIGNATURE _____ DATE _____