Meaningful Connections
COUNSELING

Registration Form

Thank you for choosing Meaningful Connections Counseling to assist with your therapeutic needs. Please answer all of the following questions so that we may be of complete and accurate service to you. While this office recognizes a number of sexes/genders, most insurance companies do not. Please complete these forms with your legal name/gender for billing purposes. If your preferred name or pronouns are different, please let us know. Please read and sign the accompanying forms. This form must be completed and signed by a legal guardian for anyone under 18 years.

Date:_____

Patient Legal Name:_____ Legal Gender: _____

Preferred/Nick Name:_____ Pronouns:_____

Address:_____City:_____

Zip Code:_____Phone (Cell):_____ Phone (Work):_____

May we leave a message: Yes___ No___ Preferred contact method:_____ Text: Yes___ No___

Email address:_____

Date of Birth:_____ Age:_____ Social Security #:_____

Employer:_____ Occupation:_____

Referred by:_____Diagnosis if any:_____

INSURANCE INFORMATION:

Please allow us to make a copy of your insurance card and ID.

Name of Holder of Insurance:_____ Ins. Holder DOB:_____

If not self: Relationship:_____ Insurance Holder's SSN:_____

Primary Insurance:_____Contract #:_____Group#:_____

Secondary Insurance:_____Contract #:_____Group#:_____

Medicaid: □ No □ Yes #_____ Medicare: □ No □ Yes #_____

I hereby consent and authorize Meaningful Connections Counseling/Advantage Billing to make any and all insurance claims on my/our behalf for the duration of my/our services at this office. I hereby give my consent to outpatient treatment by Meaningful Connections Counseling, for myself, or a child which I certify that I have legal custody of.

Client Signature:_____ Date:_____

CLIENT NOTICE OF CONFIDENTIALITY

The confidentiality of your client records is of critical importance to us. Federal law and regulations protect client records that are maintained by Meaningful Connections Counseling. No member of Meaningful Connections Counseling may discuss information with individuals outside of Meaningful Connections staff, which staff includes supervision being provided by Dr. H. Dean Dorman, as well as billing services provided by Advantage Billing. Nor, may they identify a person as a client at Meaningful Connections, unless you consent to a release of information in writing. There are several exceptions to the law and regulations. Federal law and regulations do not protect any information about: suspected child or vulnerable adult abuse or neglect, court order to release records, intent to harm others or commit homicide, or intent to commit suicide, from being reported. Similarly, if there is a medical emergency that requires identification for treatment, information may need to be disclosed.

Violation of the Federal Law and regulations by an organization is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

I_____have been provided with a copy of this notice and a copy of the recipients rights brochure, if applicable, and I understand the information presented here about client confidentiality. Further, I understand my rights and the complaint process and procedures for filing a complaint.

Client Signature_____Date_____

SOCIAL MEDIA POLICY

In our best effort to protect your privacy, we will not accept requests, invitations, or emails from clients or their first degree relatives for any social media to include, but not limited to Facebook, Twitter, LinkedIn, Pinterest, Instagram, or personal blogs. We have a monitored Facebook business page for Meaningful Connections Counseling and welcome 'likes,' but we will not respond to email or instant messaging through that site or any of the above mentioned. We are appreciative of word-of-mouth referrals, however we cannot confirm or deny past or current client's treatment to potential or new clients. If you choose to write a recommendation on a business review site for Meaningful Connections Counseling, please keep in mind that you may be sharing personal information in a public forum and we encourage you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

By signing, I agree that I have read and understand this policy on social media.

_____ _____

Signature of patient Date

MEANINGFUL CONNECTIONS COUNSELING, PLC

FINANCIAL POLICY

- I understand that payment is required at the time services are rendered unless payment arrangements have otherwise been made.

- I understand that I am responsible for the cost of all diagnostic and treatment services not covered by my insurance carrier unless otherwise indicated by my managed care contract.

- I understand that there may be additional charges for services I request, that are not covered by my insurance. These services may include, but are not limited to, phone calls lasting more than 10 minutes, clinical documentation, and preparation for and attendance at legal proceedings.

- I understand that I am required to notify my therapist of any changes in my insurance coverage and/or carrier before the next session following the change.

- I understand that as the parent or guardian of a minor receiving therapy or testing services from a Meaningful Connections Counseling provider that I am responsible for full payment.

- I understand that Meaningful Connections Counseling has a no show policy. I understand that it is the policy of Meaningful Connections Counseling to charge and collect $50.00 for each missed appointment, or cancellation with less than 24 hours notice, in accordance with this policy. I understand it is my responsibility to make this payment on or before my next appointment, and that insurance does not cover this fee.

- I understand that my therapist may elect to terminate clinical services if I fail to meet my financial obligations as defined by this Financial Policy.

- I acknowledge that I have read and understand all of the terms of this Financial Policy, and I understand that failure to pay any applicable fees may result in collection actions. I understand that outstanding balances of more than 90 days will incur a monthly service fee until paid in full. The monthly service fees are as follows: $5.00 fee for balances of $99.99 or less, $10.00 fee for balances of $100.00-$249.99, $25.00 fee for balances in excess of $250.00. I understand that I will be responsible for any and all collection fees incurred by Meaningful Connections Counseling in the effort to collect the debt, including court costs.

- I authorize Meaningful Connections Counseling to provide to its billing agency whatever insurance, demographic and diagnostic data is reasonable and necessary to obtain payment from the insurance carrier or responsible party, for the duration of services rendered to myself or my child, as well as following termination of services until payment has been made in full.

By signing this form, I agree to all of the above, and am aware of any financial obligations that I may be held to during or following my treatment at Meaningful Connections Counseling, PLC.

Signature_____ Date_____
(Responsible Party)

Witness_____Date_____
(Provider)

EMERGENCY CONTACT

For a life threatening emergency, please call 911 immediately.

This office provides outpatient care. Clinicians at this office are not on-call, and as such may not be available to address your urgent concerns. If you believe you are in danger or in imminent risk, or suicidal and/or homicidal with intent: Please do not waste valuable time calling our office. Call 911 immediately, and contact our office once you are safely at the hospital to inform your clinician of the situation.

If there is an emergency during our work together, or your personal safety becomes a concern, your therapist is required by law and by the code of our professions to contact someone close to you. This may be anyone over 18 years of age; a relative, spouse, or close friend whom you trust. We are also required to contact this person and/or the authorities, if we become concerned about your harming someone else. Please write down the name and information of your chosen contact person, as well as a second person if the first is unable to be reached. It is strongly encouraged that you inform these people of the potential to be contacted in an emergency. An emergency is as defined in this form.

Primary:
Name:_____

Phone:_____

Relationship:_____

Secondary:
Name:_____

Phone:_____

Relationship:_____

By signing this form, I am granting Meaningful Connections Counseling permission to contact my Emergency Contacts, should any of the above situations arise. I am aware that I may change my Emergency Contacts at any time.

This consent expires automatically sixty (60) days after closure of current episode of care, unless revoked and replaced with an updated form.

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____
(If Applicable)

Meaningful Connections Counseling, PLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____
Name of Client

By signing below, I am saying that I have been given a copy of the Notice of Privacy from Meaningful Connections Counseling. I know that I may ask questions about this information. Also, I can ask for limits on how my information is used or released by contacting the Privacy Officer at (269) 459-9790.

_____
Signature of Client or Personal Representative

_____
If signed by Personal Representative, relationship to client

_____
Date

For Office Use ONLY:

Documentation of Good Faith Effort

Meaningful Connections Counseling will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the Individual. If written acknowledgement is not obtained, Meaningful Connections Counseling must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Notice mailed to consumer/guardian but acknowledgement form was not returned_____
Physically unable to sign_____
Declined to sign_____
Stated s/he already had a copy_____

_____
Therapist/Case Manager Signature

_____
Date