Life Transitions Counseling

Registration Form

Today's Date ____ /____ /_____ How did you hear about us?:_____

Client's full name: _____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____) _____ CELL PHONE: (_____) _____

Age:_____ DOB: _____/_____/_____ Gender: _____

Present Employer:_____ Work Phone: (_____) _____

E-mail address:_____

Emergency Contact: _____ Relationship: _____ PH: (_____) _____

INSURED/RESPONSIBLE PARTY INFORMATION

Name of Insured: _____ Relationship to client:_____ DOB____/_____/_____

Home Address: _____

Phone: (_____) _____ Social Security Number:_____-_____-_____

Employer Name: _____

Primary Insurance: _____ ID#: _____ Group #: _____

BILLING AND INSURANCE POLICY

1. I authorize use of this form for all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I permit a copy of this form to be used in place of an original.

- It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance at the time of services rendered.
- There will be a $30 service charge on all returned checks.
- **There is a Cancellation Policy which requires that you cancel your appointment at least 24 hours in advance to avoid being charged. There is a $60 fee for late cancellations or missed appointments. Cancellations may be made by phone or via my web portal**

I understand and accept all of the terms regarding billing, insurance, and cancellation policies.

_____ _____

Signature Date

Life Transitions Counseling

Contact Preferences

In the event that your therapist needs to contact you regarding your appointment, please indicate your preference.

☐ Please contact me by e-mail at: _____@_____

☐ Please **call** my Cell Phone: (_____) _____

☐ Please **text** my Cell Phone: (_____) _____

☐ Please call my Home phone: (_____) _____

☐ Any of the Above

Voicemails:

☐ I give you permission to leave a voice mail message

☐ I do **NOT** give you permission to leave a voicemail message

Messages:

☐ I give you permission to leave a message with _____

☐ I do NOT give you permission to leave a message with anyone.

Appointment Reminders:

☐ Email (requires email address)

☐ Text Message (requires cell phone number)

☐ Phone call (requires home phone number)

☐ None (no reminder will be sent)

_____ _____

Signature Date

Life Transitions Counseling

Insurance Information

Please obtain this information prior to your first appointment if you want to use your insurance rather than paying the full fee of $150.

Name of Insurance Company: _____

Please be aware that your medical insurance provider may not be the same company that provides your mental health benefits. When you call you insurance company, please specify that you need information about your Outpatient Mental Health benefits.

Questions to ask your insurance company:

Do I need Pre-Authorization? If so, Authorization # _____

Do I have an annual deductible? Y N If yes, amount: $ _____

Have I met my deductible? Y N If no, how much is left? $ _____

Co-pay Amount: $ _____ **OR** Co-insurance Amount: $ _____

Number of visits allowed? _____

Is my visit limit per calendar year ☐ or per contract year ☐?

If contract year, when does my contract year start? _____

Does my therapist have to complete any treatment requests? Y N

If yes, after how many visits? _____

Electronic Payer ID # _____

Claims Address:_____

Insurance Contact Number: (_____) _____

Life Transitions Counseling

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Life Transitions Counseling. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment of for other business or government functions.

By signing this form you are agreeing to let us use your PHI. The **Notice of Privacy Practices** is available online and explains in more detail your rights and how we can use and share your information. We will also provide a printed copy on request. **Please read the Notice of Privacy Practices before you sign this Consent Form.**

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using and sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his/her representative Date

_____ _____

Printed name of client or personal representative Relationship to client

Life Transitions Counseling

Outpatient Services Agreement

Welcome to Life Transitions Counseling. This document contains important information about our professional services and the company's business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

THERAPEUTIC SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you 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 your life, you 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 you will experience.

Our first few sessions involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

CONTACTING US

Our telephone is answered voicemail. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you are available. If you are unable to reach us and you feel that you can't wait for us to return your call, contact your family physician, psychiatrist, or the nearest emergency room. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

SESSIONS

We normally conduct an evaluation that will last from 2-3 sessions. During this time, you and your therapist can both decide if he/she the best person to provide the services you seek in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 50 minute session per week at a time we agree on. Once an appointment is scheduled, you will be expected to pay for it

unless you provide 24 hours advance notice of cancelation (unless you and your therapist both agree that you were unable to attend due to circumstances beyond your control). The fee for missing a scheduled appointment is $60.00.

The $60 missed appointment/late cancellation fee is an out-of pocket expense it cannot be submitted to your insurance company. You are responsible for the full amount.

PROFESSIONAL FEE (excluding legal fees)

Our Initial Appointment fee for is $150 and all subsequent appointments are $110. In addition to weekly appointments, we charge $100 per hour for other professional services you may need, though we will prorate the hourly cost in 15 minute increments if we work for periods of less than one hour. Other services include letter writing, clinical telephone conversations lasting longer than 10 minutes per week, correspondence with other professionals you have authorized, preparation of records, and the time spent performing any other service you may request of us.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a payment installation plan.

If your account has not been paid for more that 60 days and arrangement have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency. If such legal action is necessary, its costs will be included in the claim. In the event that your account goes to collections, there will be a 25% collection fee added to your balance. In most collection situations, the only information we release regarding a patients treatment is his/her name, the nature of services provided and the amount due.
NSF FEE: There will be a $30 service charge on all returned checks.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will file claims with your insurance company and assist you to receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of

functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as a treatment plan or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you and your therapist feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above (unless prohibited by contract).

COURT TESTIMONY AND LEGAL FEES

We do not perform court-related evaluations for child custody nor do we testify in hearings involving child custody issues. In addition, we do not appear voluntarily at any court or administrative hearing. If you or your attorney chooses to subpoena a LTC Therapist or other personnel for court testimony, including depositions or administrative hearings, you will be charged a flat non-refundable fee of $2500 pre-paid one week in advance. In addition, you will be charged $200 per hour for any preparation time LTC personnel spend getting ready to appear, traveling to and from court, waiting to appear, and/or testifying. These charges will apply even if we are ultimately excused from testifying. By signing this agreement, you agree to pay these charges. Should it become necessary for LTC to commence collection proceedings or retain an attorney to collect any fees hereunder, you agree to pay any and all attorney's fees and costs incurred by LTC.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Patients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to require an agreement from parents that they agree to give up access to your records. It is important for minors to have a trusting environment to increase the possibility of therapeutic effectiveness. By signing the informed consent and by agreeing to undergo treatment it is understood that minors records will be kept confidential, we will provide parents only with general information about your work together, unless we feel there is a high risk that the minor will seriously harm himself/herself or someone else. In this case we will notify the parent/legal guardian of our concerns

CONFIDENTIALITY

In general, the privacy of all communications between a patient and therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a person's treatment. For example if we believe a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, we may be obligated to seek hospitalized for him/her or to contact family members or others who can help provide protection.

We may occasionally find it helpful to consult with other professionals about a case. During our consultation, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. We will be happy to discuss these issues with you, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not an attorneys.

ETHICAL OBLIGATIONS

Should you attend your therapy session under the influence of any substance that would impair your ability to safely operate a motor vehicle and upon departure from LTC, you choose to do so against your therapist's advice; we have an ethical obligation to report this to the local authorities.

Your signature below indicates that you have read the information contained in Life Transition Counseling's Outpatient Services Agreement and agree to abide by all of its terms during our professional relationship.

_____ _____

Signature of Patient Signature of Parent/Legal Guardian

_____ _____

Printed Name of Patient Printed Name of Parent/Legal Guardian

_____

Date