Life Transitions Counseling

9254 Mosby Street #B
Manassas, VA 20110

Client Registration Form

Full Legal Name _____

Name You Wish to be called by _____

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

Home Address: _____

City _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

If your therapist needs to contact you regarding your appointment, what is the best way reach you quickly and privately:

(please circle one): home cell work

Do I have permission to leave a voice mail or text at this number with appointment information? Yes ___ No ___

E-mail address: _____

Email is not always secure and could be read by a third party.
Is email an acceptable means to communicate with you? Yes ____ No _____

Appointment Reminders: (choose only one)

- ☐ Email (requires email address)
- ☐ Text Message (requires cell phone number)
- ☐ NO Appointment Reminders

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____

How did you hear about us? _____

_____ _____
Signature Date

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Insurance Information

If you want to use your insurance rather than paying the full fee,

Please obtain insurance information prior to your first appointment.

When you call your insurance company for this information, please specify that you need information about your Behavioral Health benefits.

INSURED PERSON/DESIGNATED PAYER INFORMATION

Name of Insured: _____ Relationship to client: _____

Insured DOB: _____ / _____ / _____ Phone: (_____) _____

Insured's Address: _____

Insured's Employer: _____

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

Do I need Pre-Authorization? ? **Y** **N** 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: _____ Number of visits allowed? _____

BILLING AND INSURANCE POLICIES

If you want us to bill your insurance, they require that you authorize us to provide them with a clinical diagnosis. They may also require clinical information such as treatment plans, or even the entire clinical record. To avoid this, you do have the right to pay for clinical services out-of-pocket if you should choose.

1. I authorize the release of information to my insurance company.
2. I understand that I am responsible for the full amount of my bill for services provided.
3. I authorize direct payment to my service provider.
4. I permit a copy of this form to be used in place of an original.
5. 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.
6. **The Cancellation Policy requires that you cancel your appointment at least 24 hours in advance to avoid being charged. There is a $75 fee for late cancellations or missed appointments, which is not payable by insurance.**

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

_____ _____

Signature Date

Life Transitions Counseling

Consent for Treatment

The following are the responsibilities of each client:

1. Provide to the best of his/her knowledge accurate and complete information about present complaints, prior treatment, hospitalizations, medications, and other matter pertaining to his/her treatment to this therapist.
2. Communicate to therapist his/her level of comprehension and understanding of treatment goals and treatment process, recommended frequency of sessions, as well as what is expected of him/her as part of the therapeutic process.
3. Responsible for his or her actions when he or she refuses to comply with the treatment recommendations and/or instructions of this therapist.
4. If we bill your insurance, they require you to authorize us to provide them with a clinical diagnosis. This may also include clinical information such as treatment plan updates, or even the entire clinical record. To avoid this, you do have the right to pay for clinical services out-of-pocket if you should choose.
5. Abstain from alcohol and/or drug use before and during therapy sessions. Should you attend therapy under the influence that would potentially impair you to safely operate a vehicle, therapist has an ethical obligation to report this to the local authorities for the safety of all parties.
6. Recognize that recommendations and referrals for other types of clinical services or levels care may be made if clinically deemed necessary at any time as part of the treatment process. This can include psychiatric evaluation, psychological evaluation, a higher level of care, or any additional services not specified that may be beneficial to the client.
7. Understand that this therapist does not provide court-related evaluations for child custody cases nor testify in hearings regarding child custody. Further, this therapist does not appear voluntarily for any court or administrative hearing. Please see financial responsibility agreement for legal fee information.
8. This therapist can be reached during business hours. In the case of an emergency, the client is required to utilize all emergency services available, by calling 911 and/or going to the local emergency room as well as notify this therapist. An emergency includes when the client is a danger to himself/herself or to others, as well as any medical emergency. By signing below, I acknowledge that I read the above guidelines in order to engage in outpatient counseling treatment.

By signing below, I acknowledge that I read the above guidelines in order to engage in outpatient counseling treatment. In addition, I fully understand my rights and responsibilities as stated above.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Life Transitions Counseling

FINANCIAL RESPONSIBILITY

The following are the financial responsibilities of the client and/or designated payer:

1. Have a clear understanding of your insurance benefits and what mental health services are covered, if you choose to use your insurance.
2. The payment of any deductible amount, co-pay, co-insurance, or full session fee of $150 for first session, and $135 each subsequent session, or any other outstanding balance for services rendered. Please know that you are required to keep your credit card on file via a secured 3rd party system. You card will be automatically charged the full amount for any balance that is 30 days past due.
3. The payment of fees for additional services such as writing letters to medical providers or insurance companies. Such fees are not reimbursable by insurance companies.
4. Authorizing direct payment to your service provider from your insurance company.
5. If you need to cancel or change your appointment, please provide at least 24 hours notice. **If less than 24 hours notice is given, there is a $75 charge for the missed session/late cancelled appointment**. This fee is not covered by your insurance and would be considered an out-of-pocket expense.
6. In addition to any fees owed, there is a $30 service charge fee on all returned checks.
7. Legal Fees: If you or your attorney choose to subpoena this therapist for any court-related testimony (including depositions/hearings,) you will be charged a non-refundable fee of $3000 that is pre-paid at least 2 weeks in advance. In addition, you will be charged $300/hour for any preparation time required which includes preparing to appear, traveling to and from court, waiting to appear, and testifying time. These charges will also apply even if we are ultimately excused from testifying. Should it be necessary for this therapist to start collection proceedings or retain an attorney to collect unpaid fees, you agree to pay any and all attorney fees and costs incurred by this process.

CREDIT CARD AUTHORIZATION

I, _____, hereby authorize Life Transitions Counseling to bill my credit card as listed above for professional fees. Per the Financial Responsibility Contract, I agree my credit card will be charged for professional services including the following: nonpayment of session fees, outstanding balances, appointments that I elect to pay by credit card, missed appointments, appointments that I have cancelled with less than 24 hours notice, and/or legal fees. This information will be stored securely via an online 3rd party billing/payment system. I understand that my card will be automatically charged if my account is 30 days past due. By signing below, I acknowledge that I read the above guidelines regarding the fee schedule and financial responsibilities. Further, I am authorizing billing of my credit card per the guidelines listed above.

_____ _____

Client/ Designated Payer Signature Date

Life Transitions Counseling

CONFIDENTIALITY

Confidentiality is a vital part of your treatment and our work together. All efforts are made to ensure that your health information is kept private and confidential as part of the therapeutic process.

However, as a mandated reporter, there are exceptions to confidentiality as required by state law and professional ethics:

1. Any suspicions of a child, elderly, or disabled person being abused
2. A client that may be in immediate danger to him/herself or in danger of hurting others

***Should a call be made to the abuse hotline, it is up to the discretion of the clinician whether you will be notified that a call has/will be made. The therapist is not required to share with you that the Virginia Child/Adult Protection Hotline has been contacted. Please know that this decision is often a very difficult one and is based upon therapeutic appropriateness and the health and safety of those involved.

Other times when your confidential information will be released and disclosed:

1. When you provide a signed and dated Release of Information, giving permission for specific information to be disclosed to a designated party.
2. A court order is given in which the release of the records is required and mandated by law.

In addition, I am required by law to keep treatment records. You are entitled to receive a copy of the records unless it can be considered emotionally damaging, to which they could be sent to a mental health professional of your choice and with your consent. Please know that there will be an appropriate fee charged for time spent in preparing treatment record requests.

Also, sometimes clinicians find it helpful to consult with other mental health professionals about a case. During this consultation, every effort is made to avoid revealing your identity. The consultant is also required to keep the information confidential. You will not be made aware of these consultations if you don't object to them, unless I feel it could be helpful to our therapeutic work together.

If you are under the age of 18, please be aware that the law may provide your parent/legal guardian the access to your medical record. By signing the informed consent and by agreeing to undergo treatment, both parents/legal guardians and the minor recognize that the records will be kept confidential. Parents/guardians will be provided with general information regarding counseling sessions unless there is a suspected risk that the minor is in danger of harming himself/herself or someone else. Should that occur, parents/legal guardians would be notified of our concerns.

Your signature below acknowledges that you read the above regarding the laws of mandated reporting and confidentiality.

_____ _____

Client Signature Date

_____ _____

Signature of Parent/ Legal Guardian Date

Life Transitions Counseling

ACKNOWLEDGEMENT OF

HIPAA NOTICE OF PRIVACY PRACTICES

By engaging in counseling services, Protected Health Information (PHI) will be collected about you. We utilize this information to determine the best course of treatment for you. As part of this treatment, and upon your consent and signed Release of Information, we may also share this information with others that provide treatment to you.

In order to bill your insurance company to receive payment for services rendered, we may also share this information the insurance company. This information may also be utilized for other business, government, and legal purposes.

By signing this form, you are agreeing that you have been provided a copy of the HIPAA NOTICE OF PRIVACY PRACTICES. It explains in great detail what your rights are regarding your PHI and how your PHI can be utilized and shared. This information is available on-line but also available in printed format if requested.

If you are concerned about some of your information, you have the right to request that we do not use or share some of your PHI for treatment, payment of services, or other 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.

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

After you have signed this acknowledgement, you have the right to revoke it in writing and we will comply with your request at that time. However, please be aware that we may have already disclosed or used your PHI previously before the consent was revoked. If you do refuse to sign the form, it does not prevent your PHI to be disclosed as directed by the law.

_____ _____

Client (or Legal Guardian) Signature Date

_____ _____

Printed name of Client (or Legal Guardian) Date

Life Transitions Counseling

Introductory Information

Thank you for completing this questionnaire and providing me with valuable information so that I can better assist you in the therapy process.

Name: Date:

Age: Relationship Status: Gender: Pronouns:

What concerns/issues have brought you to the office today?

TREATMENT GOALS: What do you hope to accomplish with counseling?

Have you had previous counseling? Y N When: Was it helpful? Y N

Did another professional recommend that you come to therapy? ___ Yes ____ No

Would you like to sign a release of information for me to consult with them? ___ Yes ____ No

Who is living in your household with you?

Name	Age	Relationship

Any children not living at home full time?

Name	Age

Have there been any deaths or major changes (deployment, separations, job loss, moving) in your close family recently? If yes, Who/What, When:

Please list any concerns you have about coming to therapy:

Family History - Have you (or any biological family members) had a history of:

	Myself		Family member	
Mental Illness	☐	What kind?	☐	What kind?
Substance Abuse	☐	What kind?	☐	What kind?
Medical Illness?	☐	What kind?	☐	What kind?
Suicidal Thoughts?	☐		☐	
Self Harm Behaviors?	☐		☐	
Violent Behavior	☐		☐	

Abuse History

Emotional?	☐	If yes, Age:	Abuser:
Physical?	☐	If yes, Age:	Abuser:
Sexual?	☐	If yes, Age:	Abuser:
Neglect?	☐	If yes, Age:	

Current use of:

Alcohol:	Y	N	If yes, How Often:	Amount:
Cigarettes	Y	N	If yes, How Often:	Amount:
Drugs:	Y	N	If yes, How Often:	Amount:

Other Addictive Behaviors (gambling ,shopping, internet, sex) Y N Type:

Do you have any medical concerns, surgeries or hospitalizations either current or past? Y N
If yes, please list: Condition Treating Physician

Name of Primary Care Doctor/Referring physician:
Would you like to sign a release of information for me to consult with them? ___ Yes ____ No
Last physical exam date:

Are you currently taking prescription medication? If yes, please list:
Medication Dosage Condition Physician

Check all Symptoms and Concerns that apply and indicate how long

	Symptoms	How Long?
	Sadness	
	Depression	
	Hopeless	
	Worthless	
	Helpless	
	Overly Guilty	
	Loss of interest in things	
	Feelings of being overly worried	
	Extreme or persistent anxiety	
	Panic Attacks	
	Phobias or specific fears	
	Trouble sitting still/restless	
	Trouble thinking through problems	
	Trouble with concentration/focus	
	Tired all the time/overly tired	
	Stressed	
	Heart racing/pounding	
	Intense anger and/or frustration	
	Isolation/social withdrawal	
	Easily agitated or upset	
	Irritable	
	Obsessive thoughts or behaviors	
	Thoughts or urges to hurt yourself	
	Thoughts/urges to hurt someone else	
	Persistent upsetting thoughts	
	Thoughts go really fast/scattered	
	Mood Swings	
	Worries about death or dying	
	Fear of losing control	
	Losing track of time	
	Blackouts	
	Loneliness/Feelings of being alone	
	Bursts of extreme energy	
	Lack of motivation	
	Crying/tearfulness	
	Procrastination/Avoidance of life	

	Symptoms	How Long?
	Changes in Appetite	
	Overeating/bingeing	
	Not eating enough/restricting	
	Don't have an appetite	
	Very focused on ways to lose weight	
	Changes in Sleep	
	Trouble falling asleep	
	Waking up during the night	
	Sleeping more than usual	
	Sleeping/napping to avoid things	
	Not getting enough sleep at night	
	Sleepwalking	
	Night terrors	
	Concerns in any of these areas:	
	Marriage / Intimate Relationship	
	Divorce/Separation	
	Spirituality/Faith	
	Work/Career	
	School/Learning	
	Communication	
	Stress Management	
	Money/Budgeting/Finances	
	Aging/Dependency on Others	
	Lack of close friendships/relationships	
	Sexual issues	
	Pregnancy/Miscarriage/Infertility	
	Grief/Loss	
	Past hurts that feel unresolved	
	Managing/Controlling Anger	
	Poor impulse control/Risk-taking	
	Gender Identity/Sexuality	
	Family Conflicts	
	Eating/Body Image/Appearance	
	Parenting/Parent-Child Relationship	