Shore Counseling and Consulting Clinic

INITIAL REGISTRATION PACKET

THERAPIST: _____ DATE OF FIRST VISIT: _____

LOCATION: □ MAYFAIR □ GLENDALE □ TELEMED

GENERAL DEMOGRAPHIC INFORMATION

CLIENT INFORMATION:

CLIENT LAST NAME:		FIRST NAME:		MI:
DATE OF BIRTH:	AGE:	SOCIAL SECURITY NUMBER: (OPTIONAL)		
GENDER:	RACE/ETHNICITY:	MARITAL STATUS: **S M SEP DIV WID**		
CLIENT ADDRESS: STREET		CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	EMAIL ADDRESS:		
EMPLOYER:	WORK PHONE:	MAY WE CALL YOU AT WORK? (CIRCLE) **Yes No** MAY WE LEAVE A MESSAGE AT WORK? (CIRCLE) **Yes No**		
EMPLOYER ADDRESS: STREET		CITY:	STATE:	ZIP:
REFERRED BY: (IF APPLICABLE)		REASON FOR REFERRAL:		
PRIMARY EMERGENCY CONTACT:		PHONE NUMBER:		RELATION:

PRIMARY INSURANCE: (COPY OF CARD PREFERED)

INSURANCE NAME		INSURANCE CO. ADDRESS: STREET	CITY:
STATE:	ZIP:	INSURANCE CO. PHONE:	EFFECTIVE DATE:
SUBSCRIBER NAME:		SUBSCRIBER EMPLOYER:	SS#: (OPTIONAL)
RELATIONSHIP TO PATIENT:		MEMBER ID:	GROUP #: (IF APPLICABLE)

SECONDARY INSURANCE: (IF APPLICABLE)

INSURANCE NAME		INSURANCE CO. ADDRESS: STREET	CITY:
STATE:	ZIP:	INSURANCE CO. PHONE:	EFFECTIVE DATE:
SUBSCRIBER NAME:		SUBSCRIBER EMPLOYER:	SS#: (OPTIONAL)
RELATIONSHIP TO PATIENT:		MEMBER ID:	GROUP #: (IF APPLICABLE)

FAMILY & MEDICAL HISTORY

FAMILY MEMBERS:

LAST NAME	FIRST NAME	RELATIONSHIP	PHONE NUMBER (IN CASE OF EMERGENCY ONLY)

MEDICAL INFORMATION:

PRIMARY PHYSICIAN:	DATE OF LAST EXAM:
PRIMARY PSYCHIATRIST (IF APPLICABLE):	DATE OF LAST APPOINTMENT:

NOTE: A RELEASE OF INFORMATION MAY BE REQUESTED AS PART OF YOUR ONGOING PLAN OF CARE.

LIST ANY CURRENT MEDICATIONS AND DOSAGES:

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS? (CHECK ANY THAT APPLY)

☐ Abortion/Miscarriage	☐ Chronic Pain	☐ Head Injury	☐ PMS
☐ Allergies	☐ Constipation	☐ Headaches	☐ Prostate Disease
☐ Arthritis	☐ Dental Problems	☐ Hearing Problems	☐ Sexual Problems
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Sexually Transmitted Disease (STD)
☐ Back Trouble	☐ Drinking Problems	☐ Infertility	☐ Skin Problems
☐ Birth Control Problems	☐ Drug Abuse	☐ Injury/Fracture	☐ Sleep Problems
☐ Bladder Problems	☐ Eating Disorder	☐ Irritable Bowel	☐ Speech Problems
☐ Blood Disease	☐ Emphysema	☐ Kidney Disease	☐ Stomach Problems
☐ Blood Pressure	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Thyroid Problems
☐ Cancer	☐ Fibromyalgia	☐ Low Blood Sugar	☐ Vision Problems
☐ Chronic Fatigue	☐ Hay Fever	☐ Menstrual Problems	☐ Weight Problems

☐ Other:

FAMILY & MEDICAL HISTORY (CONTINUED)

PLEASE LIST ALL PRIOR MENTAL HEALTH SERVICES RECEIVED:

WITH WHOM?	HOW LONG? (IF POSSIBLE, SPECIFY DATES)	SERVICE(S) RECEIVED?

PLEASE INDICATE ANY FAMILY HISTORY OF MEDICAL OR PSYCHOLOGICAL CONCERNS: (PLEASE INCLUDE ANY PHYSICAL/EMOTIONAL PROBLEMS, HISTORY OF ALCOHOL/SUBSTANCE ABUSE, CHILDHOOD ABUSE HISTORY, OR OTHER SIGNIFICANT EVENTS/CONDITIONS)

PRESENTING ISSUES

CURRENT AREAS OF CONCERN: (PLEASE CHECK ANY AREA WHERE YOU THINK YOU MAY NEED THERAPEUTIC SUPPORT)

☐ Addiction	☐ Grief	☐ Marital Problems	☐ School Concerns
☐ Anger/Temper	☐ Guilt	☐ Memory/Concentration	☐ Sexual Abuse
☐ Anxiety/Nervousness	☐ Emotional Abuse	☐ Menopause Issues	☐ Sexual Dysfunction
☐ Depression	☐ Indecision	☐ Nicotine/Smoking Problems	☐ Sleep Disturbances
☐ Drinking Problems	☐ Interpersonal Relationships	☐ Pain	☐ Suicidal Thoughts
☐ Drug Use	☐ Isolation/Withdrawal	☐ Panic Attacks	☐ Suicide Attempt
☐ Eating/Appetite Change	☐ Issues from Childhood	☐ Parenting Skills	☐ Tiredness/Fatigue
☐ Exercise/Hobbies	☐ Learning Difficulties	☐ Phobias	☐ Trauma
☐ Frequent Mood Changes	☐ Legal (Lawsuit/Charges)	☐ Physical Abuse	☐ Weight Loss/Gain
☐ Gambling Problems	☐ Low Self-Esteem	☐ PMS	☐ Work/Career Problems

☐ Other:

PLEASE INDICATE ANY OTHER INFORMATION THAT MAY ASSIST IN YOUR TREATMENT:

AGREEMENT REGARDING CONSENT TO TREATMENT, POLICIES, SERVICES, & FEES

Welcome to the Shore Counseling and Consulting Clinic. Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your consent to treatment and our financial policy which you are required to read and sign prior to any treatment.

All patients must complete our registration packet and insurance forms before seeing a clinician.

REGARDING INSURANCE:

Please keep in mind that all charges are the responsibility of the patient, regardless of your insurance coverage. We will file your claims with your insurance carrier. However, if your insurance has not paid within 60 days, we will expect you to work with your insurance company to receive reimbursement.

If no payment has been received within 90 days of the date of service, you will be billed for the full services rendered.

FULL PAYMENT FOR DEDUCTIBLES AND COPAYS ARE DUE **AT THE TIME OF SERVICE**. WE ACCEPT CASH, CHECKS, ALL MAJOR CREDIT AND DEBIT CARDS CARDS, AS WELL AS HSA AND FSA ACCOUNTS.

MANAGED CARE:

If you are the subscriber to a managed care policy, it is your responsibility to insure that the first session is authorized by your insurance company. We also request that you understand the requirements of your insurance carrier and inform us of what procedures we must comply with to insure payment. While our Clinic is a member of many managed care networks, it is your responsibility to ensure that your therapist is a provider for your individual policy.

CANCELLATIONS AND CHANGES OF YOUR APPOINTMENT TIME:

Unless canceled ***at least 24 hours in advance***, our policy is to charge for missed appointments up to the rate of a normal office visit. You will be billed directly for this charge. Insurance carriers do not assume any financial responsibility for failed appointment charges. Please help us to serve you better by keeping scheduled appointments.

CONFIDENTIALITY:

Information regarding your treatment at the Shore Counseling and Consulting Clinic is confidential and will not be released without your written consent. Information regarding your minor child will not be released without your written permission. Certain exceptions to these rules exist: should you be a danger to self or others, should abuse of a child or elderly person be suspected, should the proper authorities be contacted, or to the court if records should be requested by them. Please see Privacy Policy should you have any questions regarding these exceptions.

MINORS:

All information pertaining to minors will be released to their parents or legal guardians upon their request, unless it would seriously affect the therapeutic process. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for bill payment, deductible, and/or co-pay.

TREATMENT PLAN:

Therapists are responsible for informing you of tentative treatment plans regarding your therapy together; you and your therapist can modify or alter this plan as treatment continues.

EMERGENCIES:

The Clinic has 24-hour emergency coverage. Your therapist or the on-call therapist will be contacted and return your call should an emergency arise and/or immediate services be needed.

BILLING:

The agreed upon fees for professional services listed below. These rates reflect what Shore Clinic bills to your insurance company. Individual's financial responsibility will depend on insurance plans and coverage.

INITIAL INTAKE ASSESSMENT: (60 minutes for all clinicians, unless otherwise specified)

APNP, PhD, Master's: **$240**

SESSION FEE: (60 minutes for all clinicians, unless otherwise specified)

APNP, PhD, Master's level clinician: **$210**

STATEMENT OF AGREEMENT:

I, the undersigned, authorize my insurance benefits to be paid directly to Shore Counseling and Consulting Clinic and acknowledge that I am financially responsible for any unpaid balance. I also understand that a re-billing fee may be charged for any portion of my account that is over 60 days past due. By signing, I understand that my signature can be kept on file to use with all insurance claims.

Thank you for understanding our Financial and Consent to Treatment Policy. Please let us know if you have any questions or concerns.

I understand and agree to the policies outlined above.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____

INFORMED CONSENT

Shore Counseling and Consulting Clinic wants you to be aware of your rights as a patient and asks for your informed consent to receive treatment. When you meet with your counselor you will receive a statement that explains your rights under HSS.94.

A. The benefits from therapy may include, but are not limited to, being better able to meet your needs, improve communication skills, more satisfying and intimate relationships, and better understanding of your personal goals and values.
B. Therapy is conducted in individual, family, couples, or group sessions with a therapist for purposes of determining and resolved problems or concerns.
C. Therapy may include the risk of remembering unpleasant events and can arouse intense emotions of sadness, fear, and anger. Feelings of anxiety, depression, frustration, loneliness, or helplessness may also be aroused.
D. The therapist may suggest alternative treatment modes and will make referrals when appropriate or necessary.
E. If you forgo therapy, it is possible your problems may not be resolved, or may become worse than they are at the present time.
F. This informed consent will be in effect until such time that you are discharged from treatment, either by mutual agreement with your therapist, or through your own decision. Or for 15 months, whichever should come first.
G. You have a right to withdraw this informed consent at any time; your request must be in writing.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____

CONFIDENTIALITY AND DENIAL OF RIGHTS

I understand that information discussed with my therapist is confidential and will not be discussed without my release of that information. Therapists at Shore Counseling and Consulting Clinic regularly consult with clinical professionals about cases, but this information is also confidential. I am aware of my rights as a voluntary client as stated in the "Shore Counseling and Consulting Clinic's Notice of Privacy Policies."

I understand that the only exceptions to this commitment to confidentiality is when there is a court order or law requires a therapist to protect the rights of clients and others. These include instances of child abuse, threats of suicide and harm to another.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____

GRIEVANCE PROCEEDINGS

1. A patient or a person acting on behalf of a patient may file a grievance under s.HFS94.29 procedure with the administrator of a facility or other service provider or with a staff member of the facility or other service provider without fear of reprisal and may communicate, subject to s.51.61 (1)(p), Statutes, with any public official or any other person without fear of reprisal.

2. No person may intentionally retaliate or discriminate against any patient, person acting on behalf of the patient or employee for contacting or providing information to any official or to an employee of any state protection and advocacy agency, or for initiating, participating in or testifying in a grievance procedure or in any action for any remedy authorized by law.

3. No person may deprive a patient of the ability to seek redress for alleged violations of his or her rights by unreasonably precluding the patient from using the grievance procedure established under s.HFS94.29 or from communicating, subject to any valid telephone or visitor restriction under s.HFS94.05, with a court, government official, grievance investigator or staff member of a protection and advocacy agency or with legal counsel.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY POLICIES

I acknowledge that I have received a copy of the Shore Counseling and Consulting Clinic's Practices (Notice Brochure), and have been provided an opportunity to review and understand it. The notice brochure describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of health care operations. The notice brochure also describes my rights and the Shore Clinic's duties with respect to my protected health information.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Health Information Privacy Practices Brochure, but acknowledgement could not be obtained because of the following reason(s):

☐ Individual refused to sign
- ☐ Communication barriers prohibited us from obtaining acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other: (please specify)

_____

_____

_____

CONSENT FOR TELEMED SERVICES

Adapted from APA Guidelines

1. I understand there are potential benefits and risks of telemed sessions that differ from in-person sessions.
2. I acknowledge that confidentiality applies for telepsychology services in the same manner as in-person sessions. Sessions will not be recorded without permission from all individuals.
3. I agree to using video-conferencing or telephone platforms; your provider will explain how to use selected technology if necessary.
4. I understand the importance of being on time to appointments. I understand that canceling a session less than 24 hours in advance, or failing to come to a session will result in a $75 fee that is not covered by insurance.
5. I understand all minor clients will need permission from a legal guardian or parent to engage in telepsychology sessions.
6. I understand that if insurance fails to cover telepsychology sessions, I will be responsible for paying the full price of the session.
7. I acknowledge that for whatever reason, my provider determines telepsychology is no longer appropriate, the decision may be made to resume in-person sessions.

By signing this form, I certify:

- That I have read and/or had this form read or explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____