CLIENT REGISTRATION FORM

By completing this form, you are providing our office with important basic information for our records. Please print clearly.

CLIENT NAME: ______________________________
FIRST MIDDLE LAST

CLIENT ADDRESS: ______________________________
STREET CITY STATE ZIP COE

SOCIAL SECURITY NO.: ____________________ **D.O.B.:** ____________________

PARENT (S) OF MINOR: ______________________________

HOME PHONE NUMBER: ______________________________

CELL PHONE NUMBER: ______________________________

HOME PHONE NUMBER: ______________________________

EMAIL ADDRESS: ______________________________

EMERGENCY CONTACT

NAME: ______________________________

ADDRESS: ______________________________

____

PHONE NUMBER: ______________________________

POLICY HOLDER INSURANCE INFORMATION

INSURED'S NAME: ______________________________

INSURED'S DATE OF BIRTH: ____________________ **INSURED'S SOCIAL SEC. NO.:** ____________________

INSURED'S ADDRESS: ______________________________

INSURANCE COMPANY: ____________________ **INSURANCE PHONE NO.:** ____________________

MEMBER I.D. NUMBER: ____________________ **GROUP NUMBER:** ____________________

EMPLOYER NAME: ______________________________

As of this date, the information above is accurate, and I have given Finding Balance, Ltd. a copy of my insurance card (if applicable). I know that it is my responsibility to notify the office of any changes in insurance coverage, and that failure to do so, will result in me being held responsible for any uncovered charges. I further understand that benefit quotes given by my insurance carrier are considered estimates, and that they may not accurately reflect my benefit allowance. It is my responsibility to routinely review the explanation of benefits provided to me by my insurance carrier, and to notify Finding Balance, Ltd of any discrepancies.

CLIENT PERSONAL INFORMATION

Relationship Status:

_____ Single
_____ Married
_____ Domestic Partnership
_____ Divorced
_____ Separated
_____ Widowed

Spouse/Partner's Name ________________________________ **How long together?** ____________

If separated/widowed, length of time: ____

Do you have children? YES NO **If yes, do they live with you?** YES NO

Children/Sibling Information:

NAME	AGE

Have you been in counseling before? YES NO

If so, please list previous therapist's names, date(s) and duration of treatment below:

THERAPIST/FACILITY NAME	DATE(S)	DURATION OF TREATMENT

What was helpful or not helpful with previous treatment?

What brings you to Finding Balance?

MEDICAL HISTORY

Have you ever been hospitalized?   YES   NO

DATE (S)	REASON

Are you currently under a doctor's care?   YES   NO

Physician Name: ____

Are you currently taking medication?   YES   NO

List of current medications: ____

Do you drink alcohol? Yes/No If so, what and how often? ____

Do you use illicit drugs (including prescription medication that is not yours)?   YES   NO

If so, what and how often? ____

Is there any family history of alcoholism, drug abuse or mental illness?   YES   NO

If so, please explain:

COMMUNICATION CONSENT:

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Administrative Simplification of this act is a concern to us, and requires us to comply with specific rules regarding the following:

- **Unique identifiers for health plans, providers, individuals and employers**
- **Healthcare transactions & code sets for transmitting electronic data**
- **Privacy regulations over the disclosure and use of health information**
- **Security regulation over protections of electronic health information**

The policy of Finding Balance, Ltd. is not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, email, cell phone, and text or pager messages. This means that if we return a phone call, we will not leave a detailed message, unless we have your consent to do so.

I, ______________________________________, authorize Finding Balance, Ltd. to leave a detailed message, including reference to appointment times, and call back number on the following:

Home Phone Voicemail	**Yes**	**No**	**N/A**
Work Phone Voicemail	**Yes**	**No**	**N/A**
Cell Phone Voicemail	**Yes**	**No**	**N/A**
Text Message	**Yes**	**No**	**N/A**
Email	**Yes**	**No**	**N/A**

I authorize the following individuals to have access to my treatment information:

NAME	RELATIONSHIP

Consent for Email and Text: Please note that email and text correspondence are not secure modes of communication, and it is possible that information transmitted via email or text, can be accessed and read by unauthorized persons. While the modes we use to communicate via email or text are encrypted, yours may not be. We will only communicate with you using email or text if you expressly authorize us to do so. Your signature below indicates that you provide us with that authorization. In the event, that we have any concerns regarding communication utilizing email or text; even if you have provided authorization, we reserve the right to decline these modes of communication.

I authorize Finding Balance, Ltd. to communicate with me using email and/or text: YES NO

Email address: ______________________________ **Cell Phone Number:** ____________________

Signature: ____ **Date:** ______________

RELEASE OF INFORMATION

I authorize the use and disclosure of the following health information about me by Finding Balance, Ltd. I understand that such disclosures can only be made to the person(s) or organizations identified below, and only for the time indicated. I have a right to revoke this Release of Information at any time.

Persons or Organizations receiving the information:

Name: ______________________________ Title: ______________________________

Address: ______________________________

____

Release of Information is effective for the following dates:

Start ____________________ End ____________________ Open Ended ____________

SPECIFIC INFORMATION TO BE USED OR DISCLOSED:

______ Psychiatric Assessment/Diagnoses

______ Psychological History

______ Course of Therapy

______ Psychosocial Testing

______ General History

______ Coordination of Care

______ Legal Purposes/Court Purposes

______ Family History

______ Educational Purposes

______ Other

Client Name: ______________________________

Client Signature: ______________________________

Parent Signature (of applicable): ____________________ Date: ____________

As of (date) ______________________, I wish to revoke this Release of Information.

CONSENT FOR TREATMENT

This is your therapy and you are the expert on your life. Our expertise is human behavior. We will work collaboratively with you to explore your thoughts, feelings, beliefs and behaviors, in order to assist you in seeing options/alternatives for change. We will work together at establishing goals, and routinely evaluate your progress, to ensure you are getting what you need and want. In signing this consent, you are stating that you understand that psychotherapy is not an exact science, and that change can be difficult. Outcomes are dependent on many factors, including the willingness of the client to initiate a different course of action in patterns of behavior or thought. In addition, at any time, it is your right to decline treatment recommendations. As your therapists, we welcome questions and input throughout this process.

I, ______________________________________, give my consent for services for myself or my child/legal dependent, ___________________________, with Finding Balance, Ltd. including assessment, psychotherapy, testing (if indicated) and involvement in the treatment planning process.

Client Signature: ____ **Date:** ____________

Parent/Guardian Signature: ____________________________________ **Date:** ____________

Consent for Release of Information To/From Physician:

Pursuant to Law: You are hereby informed that it is desirable for you to talk with your **primary care physician, or your child's pediatrician,** regarding seeking mental health services. Below please indicate whether you give consent for me to provide this notification.

I, ______________________________________, give my consent to Finding Balance, Ltd. to discuss my condition, or that of my child/legal dependent, with my **primary care physician,** or in the case of a minor child, pediatrician. I also consent to the release of any medical documentation to/from my primary care physician for the purposes of treatment.

____ Yes, I consent ____ No, I do not consent

Primary Care Physician: ____

Address: ____

____

Phone Number: ____

Client Signature: ____ **Date:** ____________

Parent/Guardian Signature: ____________________________________ **Date:** ____________

FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered to be your obligation, in exchange for our provision of services to you and your family. The following is a statement of our Financial Policy, which is required for you to read and sign prior to the start of treatment. If the client is a minor child, the parent(s), legal guardian, or when indicated, the custodial parent is responsible for signing.

1. Insurance and Payments:

Your insurance policy is a contract between you and your insurance company. Finding Balance Ltd. is not a party to that contract. Prior to your first session, we strongly encourage you to contact your insurance company and research the details of your benefits; how you can expect to obtain reimbursement, what percentage you can expect to receive, what conditions are covered, deductible amounts and any co-payment/co-insurance amounts that might apply.

It is the client's responsibility to have full knowledge of their coverage before services are provided. This incudes, knowledge of co-pays, deductibles, and out-of-pockets expenses.

In-Network:

We are a preferred provider for specific but not all insurance companies and if your insurance company is one in which we are a preferred provider, as a courtesy, we will process your claims for you. However, all co-payments, deductibles, and co-insurance amounts will be due at the time of service. **Deductibles have to be met on an annual basis before any benefits begin.**

Out of Network or No Coverage:

If you are uninsured, have chosen not to file with your insurance, or are a member of a plan in which we don't participate, *Full Payment is Due at the Time of Service*. For individuals with non-participating plans, we will provide you with monthly documentation upon request, including visit dates, diagnosis, etc., to support reimbursement by your insurance carrier. If you would like us to process your claims for you we will do so for a reasonable fee, and if applicable, not accept assignment of benefits and/or request insurance reimbursement is sent directly to you. As a non-participating provider, we do not honor any usual and customary discounts set by your insurance carrier.

Payments:

All payment can be made by check, cash or Credit Card. All clients are required to have a valid credit card on file with us (form on last page). Returned checks will incur a $30 fee, in addition to any bank charges imposed, and the full amount of the payment. If an account is overdue by 120 days or more, it will be subject to collections, and you will be responsible for interest charges on the account, as well as fees imposed by the collection agency. In the event that legal action is necessary to receive payment, you will be responsible for all charges incurred in the legal process, including, but not limited to, attorney fees, court costs, and time spent on collection efforts.

2. Cancellations, Missed, and Re-Scheduled Appointments:

Please understand that when you make an appointment, we set aside that date and time specifically for you, and adjust our schedule, and other client times accordingly. If you need to cancel or reschedule an appointment, we require at least 24 hours-notice in advance of the appointment. This allows us time to offer the appointment to a client who would otherwise have to wait to be seen. Cancellations with less than 24 hours notice, or missed appointments, will result in the full session fee being charged to your account. This will be reflected as “Missed Appointment” on your invoices. Payments for missed appointments are due at the time of your next scheduled appointment or within 30 days, whichever comes first. Insurance companies do not reimburse for late cancellations or missed appointments; therefore the payment is your responsibility. If we must cancel or reschedule an appointment, or in the event that we miss an appointment, you will not be charged, and we will offer you a comparable appointment time.

3. Appointment Length/Late Arrivals:

Appointment times are 45-60 minutes in duration, based on the length of time billable by insurance companies. We will make every effort to start and end sessions on time. The few minutes in between appointments allows us to return phone calls, perform needed documentation, consult with other health care professionals, etc., and ensures that we are timely in starting our next session. We ask that you respect this by coming to your scheduled appointment on time. If you find that you will be late for an appointment, please understand that we cannot provide you with the full amount of your appointment time, as it would cause a delay in responding to, or seeing other scheduled clients. We will be happy to meet you for the duration of time remaining, or you may reschedule. Rescheduling will be treated as a missed appointment, unless the appointment is cancelled with a minimum of 24 hours notice. Please notify your clinician if you are running late by 10 minutes or more.

4. **Administrative Costs for Additional Ancillary Services:**

Phone Calls:

We are available by phone or by email should you need to consult with us between sessions. Calls that run longer than 10 minutes are considered partial sessions, and will be billed on a pro-rated basis according to our hourly rate, billed to the client directly. Frequent calls between sessions may incur a partial session fee, but we will discuss this in more detail should it occur. Upon your request, and with the proper release of information, we are happy to collaborate by phone with other treatment providers, schools, parents, etc., in providing continuity of client services. Phone sessions are possible at the discretion of the therapist, but are not reimbursed by insurance companies, and therefore are your responsibility. The fees are calculated using the self-pay hourly rate.

Print Name: ____

Signature: ________________________________ **Date:** ____________

CLIENT RESPONSIBLITY/FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage. It is my responsibility to understand and have personally verified if my insurance is contracted with this practice.

I hereby authorize Finding Balance Ltd. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding client responsibility amounts. I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these checks to Finding Balance, Ltd. immediately upon receipt.

RESPONSIBILITY FOR PAYMENT

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to me.

RESPONSIBILITY FOR CO-PAYMENTS

I agree to pay all applicable health plan co-payments at the time of service.

PAYMENT DUE DATE

I understand that all health plan deductibles and charges for non-covered benefits are due and payable upon presentation of a billing invoice from Finding Balance, Ltd.

HMO CLIENTS

HMO requires notification by the member for funds/payment to be released. If I have an HMO plan, I agree to contact my insurance company personally and on a timely basis to request that payment be released to Finding Balance, Ltd. for sessions that have been completed and billed.

CLIENT OR AUTHORIZED PERSONS' SIGNATURE:

I acknowledge that I have read the above payment and financial policies of Finding Balance, Ltd. and will abide by them. I further authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits to myself or to the party who accepts assignment.

Thank you for your understanding of our financial policies. Please let us know if you have any questions. By signing below, you are stating that you understand, agree, and abide by these terms and conditions.

Print Name: ____

Signature: ______________________________________ **Date:** __________

CREDIT CARD POLICY

All clients are **required** to have a valid credit card on file with Finding Balance, Ltd. The card on file can be used to cover weekly charges, such as deductibles, copayments, coinsurances and/or agreed upon rates, if you choose to pay by credit card.

Cancelled appointments, sessions cancelled with less than 24 hours notice, and any unpaid balance on your account greater than 30 days past due, will automatically be charged to the card on file. Your credit card statement will act as your receipt unless you request a formal one to be e-mailed to you.

In addition, any disputed charges that result in a charge back fee(s), as determined by the credit card processing service, will be your responsibility to pay in addition to the original disputed transaction amount.

It is your responsibility to update Finding Balance, Ltd. of any changes to your credit card information (type of card, expiration date, etc.).

By signing below, you acknowledge your understanding of the above information and agree to these terms.

Client/Guardian Signature: ______________________________

Email Address (for receipts): ______________________________

Credit Card Information will be collected on the next page.

I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with invoices for any balance due after insurance payment.

I understand that the practice may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the practice to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party.

My signature below confirms that I have read these billing policies and my financial obligations

Signature: ______________________________ **Date:** ____________

CREDIT CARD AUTHORIZATION FORM

All information will remain confidential

Cardholder Name (as shown on the card): ______________________________

Billing Address: ______________________________

City, State & Zip: ______________________________

Credit Card Information

Card Type: VISA MasterCard Discover American Express

Other: ______________________________

Card Number: ______________________________

Expiration Date: ______________________________ Security Code/CVV: ______________________________

Authorization

I authorize Finding Balance, Ltd. to charge my credit card for the agreed upon amount. I understand the above information will be saved to my file for future transactions. If an outstanding balance exists beyond 30 days, the Credit Card on File will be charged automatically.

Print Name: ______________________________

Signature: ______________________________ **Date:** ____________

HIPAA/NOTICE OF PRIVACY PRACTICES

In accordance with HIPAA laws, this notice describes how your health information may be used or disclose and how you, the client, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our clients protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

The law also establishes client rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information.
- You have the right to request in writing to inspect and/or receive a copy of your health information
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the care.

Please designate who our office CAN disclose your health information to by completing the information below:

NAME	RELATIONSHIP	PERMISSION TO DISCLOSE INFORMATION

Please designate HOW are office can disclose health information to you and others you have designated be completing the information below:

HOW INFORMATION MAY BE DISCLOSED	PERMSION TO DISCLOSE INFORMATION
Email	
Text	
Voicemail/Answering Machine	
In person Meeting	
Written/Letter	

______ DO NOT RELEASE ANY INFORMATION to anyone other than myself (the client)

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Print Name: ______________________________

Signature: ______________________________ **Date:** __________

If person signing is not client, please provide:

Relationship to Patient: ______________________________

Print Name ______________________________ **Date:** __________

**** We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. ****

GENERAL INFORMATION/CLIENT PRIVACY

Your privacy is important to us. Finding Balance, Ltd. complies with current state and federal privacy standards. Your health information will not be released by our office without your express permission except under required state and federal legal statutes. If you would like to authorize our office to release your personal medical information to another individual i.e.: husband, wife, parent, adult child, sibling, please sign the authorization below. You may revoke this authorization at any time by notifying our office in writing.

I hereby authorize Finding Balance, Ltd. to release my medical information to the following individual: ____, relationship: _________________________

I understand that I may revoke this authorization at any time by notifying Finding Balance, Ltd. in writing of my intention.

Print Name: ____

Signature: ____ **Date:** ____________