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NEW CLIENT REGISTRATION FORM

(Please complete and bring to first session)

Client Information (please print clearly)

Name________________________________ Name______________________________

Address______________________________ Address____________________________

______________________________ ____________________________

Date of Birth ___/____/_________ Date of Birth___/____/_______

Best Phone Contact ____________________ Best Phone Contact____________________

Email Address_________________________ Email Address_______________________

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Student

Employer/School: ___________________________

Billing Information:

Bill my insurance? ☐ Yes ☐ No Please provide a copy of your ins. card

PRIMARY INSURANCE
Insurance co. name: _____________________________
Insured's name: ______________________
Insured's Employer: __________________
Insured Identification #__________________________
Group ID#_____________________

Insured's date of birth ___/___/______
Insured's phone number ________________
Insured's email contact: ________________
Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child

FEE SCHEDULE

INDIVIDUAL Counseling per 50 minute session	$130.00
COUPLES/MARITAL Counseling per 50 minute session	$150.00
FAMILY Counseling per 50 minute session	$150.00
LETTER WRITING AND DOCUMENT PREPARATION	$35.00 PER 15 MIN

I understand that these rates may increase periodically, and that I will be informed prior to any rate change.

If using insurance for payment, I understand that if my clinician is in my network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with the insurance company. Further, I understand that my clinician may not charge me for the difference between the fees listed above and the agreed upon usual and customary rate, beyond the co-pay required by my insurance. I understand that my co-pay or co-insurance is _____________. I understand that this fee is due at the time of service. If not using insurance for payment, I understand that I am responsible for the full charges of each session at the time of service, unless an alternate arrangement is made with the clinician. If using insurance for payment, I understand that my insurance company reserves the right to refuse payment for services they previously pre-certified. I understand that in such a case, I have the right to appeal to my insurance company for payment. I understand that I am ultimately responsible for services provided which are not covered by my insurance company.

Signature of Client or Legal Representative: ______________________________Date:____________

Signature of Clinician:_______________________________________ Date:____________

RELEASE OF INFORMATION FOR PROCESSING BENEFITS

I hereby authorize **Symmetry Counseling, LLC** to release any of the following requested information for the purpose of obtaining reimbursement for services.

Information may include:

- Admitting Diagnosis
- Final Diagnosis
- Discharge Summary
- Designated clinical records (e.g., treatment plans, progress notes, test results, etc.)

Information may be released to any or all of the following as needed:

- Any third party payer having responsibility for payment of charges for treatment
- Review agents/auditors
- Managed Care agents

This consent is valid until such time that all claims have been settled to the satisfaction of Symmetry Counseling, LLC or up to one year from the date of discharge from treatment, whichever is longer.

I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize **Symmetry Counseling, LLC** to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate the consent any time before the expiration date so long as I submit my revocation in writing this office. Finally, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

Client's Name:________________________ Signature:____________________________ Date:______
(client or authorize representative)

Witness: ___________________________________ Date:________

Notice of Privacy Practices- Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

Please note that **Symmetry Counseling, LLC** is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our patients' personal information. You can be assured that our practice goes beyond what is required by HIPAA. Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This form is a summary of the full Notice of Privacy Practices (NPP) which is available if you would like more information.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services and for some other business activities which are called, in the law, health care operations. After you have read this NPP and discussed it with your doctor and/or therapist we will ask you to sign a Consent Form to allow us to use and share your information as needed. Please note that **Symmetry Counseling, LLC** will continue to have you complete releases of information in addition to this document. If you do not consent and sign this form, we cannot treat you.

Symmetry Counseling, LLC utilizes an electronic billing service to process claims via the internet. Rest assured that our office has taken great care in selecting the billing company with whom we have contracted. Each step in the process is encrypted to ensure the highest standard in privacy regarding sensitive personal information.

If there is a need to disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this. Of course we will keep your health information private, but there may be times when the law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these which do not happen very often. They are described in the longer NPP.

Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place whichever is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, well will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records. A fee may be associated with this service. Contact our Privacy Officer to arrange to see your records.

4. If you believe the information in your record is incorrect or missing important information, you can ask us to make changes (called amending) to your health information. You must make this request in writing to your doctor and/or therapist or our Privacy Officer. In your request, you must tell us the reason(s) you want to make the changes.

5. You have the right to a copy of this notice. If we change the NPP we will notify you as soon as possible and you can always get a copy of the NPP from our Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

I, hereby acknowledge receipt of **Symmetry Counseling, LLC** Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.

I understand that **Symmetry Counseling, LLC** has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

□ **Symmetry Counseling, LLC** may leave a message on client's/family voicemail confirming your appointment and/or information you request regarding your treatment.

□ **Symmetry Counseling, LLC** may not leave a message on client's/family voicemail.

Signature of Client:_______________________________ Date:_____________
Parent/Guardian:_________________________________ Date:_____________
(Please specify relationship to client)
Signature of Clinician:_________________________________ Date:____________

Consent for Treatment

I, ________________________, freely give my consent to take part in psychological treatment.
I believe I understand the basic ideas, goals, and methods of this therapy. With enough knowledge, and without being forced, I enter into treatment. The therapist has addressed my questions and/or concerns regarding confidentiality and the therapy process. I understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this therapist's willingness to use and share his or her knowledge and skills in good faith. Periodically during treatment, we will evaluate progress and may change treatment goals as needed. If it becomes clear that there is a need to transition care to another therapist for any reason (e.g., the nature of symptoms being addressed, misfit of personality, lack of progress etc.) I agree to discuss these concerns with my therapist and to participate in planning for transition to a new therapist if the issues cannot be resolved.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party.

I understand that 24-hour notice is required for the cancellation of a session. If 24-hour notice is not given, I understand that I am responsible for a fee of $75, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.

My signature below means that I understand and agree with the points above

Signature of Client:________________________________ Date:___________

I have discussed the issues above with this client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist: _____________________________ Date:___________