Therapy Today
COUNSELING & CONSULTING

4572 S. Hagadorn Rd, STE 1C, East Lansing, MI 48823

Phone: 517-481-2133 ~ Fax: 517-659-5934

www.therapytodaycc.com

New Patient Registration Form

Please print clearly, fill in all information

Name: _____ **Date of Birth**: _____

Physical Address: _____

City/State/Zip: _____

Mailing Address: ☐ **Same As Above**

_____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

SSN: _____ **Email:** _____

Pronouns: ☐ **He/Him** ☐ **She/Her** ☐ **They/Them** **Other:** _____

How would you like to receive appointment reminders? ☐ **Email** ☐ **Text Message** ☐ **Phone Call**

Emergency Contact: _____ **Phone:** _____

Responsible Party (If Different from Above)

Name: _____ **Phone:** _____

Address: _____

Insurance Information

Primary Carrier: _____

Subscriber/Contract Number: _____ **Group Number:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Address: _____ **Relationship to Client:** _____

Secondary Carrier: _____

Subscriber/Contract Number: _____ **Group Number:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Address: _____ **Relationship to Client:** _____

Please Read Carefully

Authorization for Release of Information for Billing Purposes

I hereby authorize the release of information necessary for third-party claim submission and/or payment for services. I authorize payment of third-party benefits to Therapy Today Counseling & Consulting LLC for therapy services provided. I understand that I am responsible to pay Therapy Today Counseling & Consulting LLC for all therapy sessions rendered. Additionally, I understand there is a fee of $50 for any no show or late cancellation, less than 24 hours prior to my scheduled appointment.

Signature: _____ **Date:** _____

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Notice of Policies and Practices to Protect the Privacy of Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCOLSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This federal government published regulations designed to protect the privacy of your health information. These privacy regulations, part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), came into effect April 14th, 2003. As part of these requirements, we are required to provide you this "Notice of Privacy Practices" that describes our responsibilities and your rights under these new regulations. The Untied States Department of Health and Human Services (HHS) states that the privacy regulations have three major purposes: 1) to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; 2) to improve the quality of health care in the U.S., by restoring trust in the health care system among consumers, health care professionals, and the multitude of organizations and individuals committed to the deliver of care; and 3) to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, individual organizations, and individuals.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *personal health information (PHI), for treatment, payment, and healthcare operations purposes with your consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
    - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another *therapist*.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
    - *Use* applies to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
    - *Disclosure* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when the appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or healthcare operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) I have relied on the authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosure with Neither Consent or Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child abuse*: If I have reasonable cause to suspect child abuse or neglect, suspicion must be reported to the appropriate authorities as required by law.
- *Vulnerable and Frail Adult Abuse*: If I have reasonable cause to suspect you have been criminally abused, this must be reported to the appropriate authorities as required by law.
- *Health Oversight Activities*: If I receive a subpoena or other lawful request, I must disclose the relevant PHI pursuant to that subpoena or lawful request.
- *Judicial and Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety*: If you communicate to me a threat of physical violence against a reasonably identifiable third person and if you have the apparent intent and ability to carry out that threat in the foreseeable future, I may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If I believe that there is an imminent risk that you will inflict serious physical harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation*: I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and our Clinician's Duties

Patients' Rights:

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosure of protective health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy*: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of this request and denial process.
- *Right to Amend*: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request I will discuss with you the details of the amendment process.
- *Right to Accounting:* You generally have the right to receive an accounting of disclosures of PHI. On you request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Your Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Leslie Auld LMSW ACSW at 517-481-2133.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14th, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

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Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Client Name: _____

Date of Birth: _____

Please sign below to acknowledge that you have been given an opportunity to read this Notice of Privacy Practices. This page will be placed in your client file to indicate you have been provided with a copy of the Notice of Privacy Practices under HIPAA as required by law.

_____

Signature of Client or Parent/Guardian **Date**

Informed Consent and Authorization for Psychotherapy

Therapists specialize in helping people with relational and life issues. There are many different types of therapy, and I tend to use an eclectic approach which takes into consideration where a person has been in their life and the many factors which are effecting how a person is doing now.

Should you choose to proceed, a positive outcome then becomes our mutual responsibility. This begins with your trust in and commitment to the treatment process, and my commitment to you as your therapist, helping you find healing and wholeness in your thoughts, feelings, behaviors, and personal values, while you discover more rewarding ways of living your life.

In addition to being a clinical process, therapy involves a professional arrangement, regulated by laws, ethics, your rights as a client, and my standard business practices. Before therapy can begin, however, our agreement to the business practices described herein is required by initials at specified places and your signature.

PAYMENT OF FEES

Paying for therapy is often a very sensitive topic, and we can discuss your concerns about payment as needed. This section clarifies all fees, and defines your financial responsibilities.

1) (SELF PAY ONLY) Your fee is _____ (please fill in amount) per 60 minute session, payable each session and beginning at your first appointment.
2) Cancelling appointments requires a **24 hour notice by phone or email** to avoid paying a cancellation fee of $50.00 for a missed session. Please note that your cancellation fee will be directly charged to the card I will have on file for you unless we have made other arrangements.
3) Please note that I give each client one "freebie" for one emergency with less than 24 hour notice.
4) Written reports requiring more than 15 minutes to prepare and complete are billed to you proportionally at $120.00/hr.
5) Appearing at meeting(s) or legal proceedings on your behalf is not covered by insurance, and is billable to you at $155/hr for the entire time spent away from the office.

Your initials here agreeing to the "Payment of Fees": _____

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1) Normally, everything we discuss will be held confidential. Unless you provide a signed authorization, I will not speak to or correspond with anyone but you.
2) Michigan law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some "exceptions to confidentiality" include situations in which there is a reasonable suspicion that any of the following has ever occurred or is occurring now:
    a. You or your child present a danger to self or other

b. A child or dependent adult is the victim of emotional, sexual or physical abuse, or neglect

LIMITS OF COMMUNICATION

1) Every effort will be made to assist you, especially during crisis. However, there may be times when contacting you won't be possible. Therefore, you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time you are in danger of harming yourself.
2) If our initial contact was made by email, please note that e-mail and text messages are not confidential methods of communicating. Please note that I will not discuss clinical material via e-mail or text message for reasons of protecting you. In addition, it violates your confidentiality to communicate with me via any form of an online social network such as Facebook.

ENDING YOUR THERAPY OR LIFE COACHING

1) If at any time during the course of your therapy, I determine I cannot continue, I will end with you and explain why this is necessary. Ideally, therapy ends when we agree together that your treatment goals have been achieved.
    a. You have the right to stop therapy at any time. If you make this choice, referrals to other therapists will be provided and you will be asked to attend a closure session.
    b. Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefits. We will discuss this together regularly.

AUTHORIZATION TO COMMENCE PSYCHOTHERAPY

- Your signature below will verify that you have read (or that I have read to you) the information in this authorization and that you asked questions about anything you have not understood up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods, as I deem appropriate and in accordance with this "Informed Consent"
- You also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financial responsibility for payment of all fees as described, regardless of insurance coverage or any other "third-party" payers.
- You will also be releasing me of any liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will be provided.

Clients signature _____ Today's date: _____

Parent/Legal Guardian Name (Print) _____

Parent/Legal Guardian Signature (if applicable) _____ Date: _____

Parent/Legal Guardian Name (Print) _____

Parent/Legal Guardian Signature (if applicable) _____ Date: _____

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Credit Card Information

Your credit card number will be kept on file in a secured and locked location for purposes of charging your co-pay/co-insurance/deductible and/or flat $50.00 cancellation fee per missed session (if 24-hour notice is not given). If out of pocket expenses are owed on your date of service and no payment is made, we will run your credit card on file to cover these expenses.

Please circle type of card: **VISA** **MASTERCARD** **DISCOVER** **AMEX**

Name of Cardholder:_____

Name of Client (if different from Cardholder):_____

Credit Card Number:_____

Expiration Date:_____ Three-Digit Security Code:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Signature of Cardholder:_____

How would you like to receive your receipt? (circle one) Email Mail None

Email:_____

Phone Number:_____

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Authorization to Release/Obtain Information

You should consider filling out this release of information if there is an individual (such as a spouse or parent) that you would like us to be able to speak with on your behalf regarding: scheduling, billing, payments, attendance, etc.

I, _____, give authorization for Therapy Today Counseling & Consulting to discuss information relevant to my case with the below-named person (ex. Spouse, partner, parent, doctor, etc.)

Individual to Release Information To:

_____

Address: _____

Phone Number: _____

Information Discussed is to be limited to:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Treatment Plan/Summary
- ☐ Current Treatment Update
- ☐ Presence/Participation in Treatment
- ☐ Billing
- ☐ Continuing Care Plan
- ☐ Progress in Treatment
- ☐ Psychotherapy Notes
- ☐ Educational Information
- ☐ Discharge/Transfer
- ☐ Scheduling Future Appointments

The authorization is valid from the date signed until a year after unless an alternate expiration date is listed:

Date of expiration: _____

Signature of Client or Parent/Guardian: _____

Date Signed: _____

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Verification of Insurance Benefit

I have been informed that I should contact my insurance carrier to verify coverage, and to identify any out-of-pocket expenses for services.

I have also been informed that any out-of-pocket expenses are due on the date of service unless other financial arrangements have been made.

Client Name: _____

Date: _____

Signature of Client or Parent/Guardian: _____

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Submitting Insurance Information

I understand that any and all insurance information to be billed must be provided on or before the date of service in order for claims to be submitted to my insurance company. Insurance claims cannot be submitted for sessions that have already taken place and/or have been submitted to insurance(s) for consideration.

Signature of Client or Parent/Guardian Date

Informed Consent Checklist for Teletherapy Services

Prior to starting video-conferencing services, we agree to the following:

- There are potential benefits and risks of video-conferencing (e.g., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for teletherapy services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing selected for our virtual sessions, TherapyAppointment or Doxy.me and the therapist or Therapy Today staff will explain how to use it.
- You need to use a webcam or smartphone during the session
- It is important for your care to be in a quiet, private space that is free of distractions during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi to protect your confidentiality.
- If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email or call the Therapy Today office at 517-481-2133.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or reschedule it, in the event of technological problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in teletherapy sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, contact Therapy Today staff or your therapist to discuss other options.
- As your therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person. Should this occur, I will recommend a source for in-person therapy.
- You agree to be located within the state of your therapist's licensure during session in order to comply with insurance and licensing regulations.

Client Name: _____

Signature of Client or Parent/Guardian: _____

Date: _____