Therapy Today
COUNSELING & CONSULTING

New Patient Registration

Demographic Information

Name:	Date of Birth:	Pronouns: *He/Him, She/Her, They/Them, etc*
Primary Phone #:	Email:	
Automated Appointment Reminders: ☐ Text ☐ Email ☐ Call		Social Security Number:
Primary/Physical Address:		City:
State:	Zip code:	
Mailing Address: ☐ Same as primary address above	*Street Address/City/State/Zip*	
Emergency Contact:	Phone #:	

Insurance Information

Primary Insurance Carrier:	Contract/Subscriber #:	Group #:
Subscriber's Name:	Subscriber's Date of Birth:	Relationship to Client:
Subscriber's Address: *Street Address/City/State/Zip*		☐ Same as primary address above
Secondary Insurance Carrier:	Contract/Subscriber #:	Group #:
Subscriber's Name:	Subscriber's Date of Birth:	Relationship to Client:
Subscriber's Address: *Street Address/City/State/Zip*		☐ Same as primary address above

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
Client Name

case with: _____ _____ _____
ex. Spouse/partner, parent, doctor, etc. *Phone #* *Address*

The following information can be discussed:

- ☐ All information relevant to my care
- ☐ Assessment
- ☐ Billing
- ☐ Continuing Care Plan
- ☐ Current Treatment Update
- ☐ Diagnosis
- ☐ Discharge/Transfer
- ☐ Educational Information
- ☐ Presence/Participation in Treatment
- ☐ Progress in Treatment
- ☐ Psychotherapy Notes
- ☐ Scheduling Appointments
- ☐ Treatment Plan/Summary

The authorization is valid for a year after the date signed unless an alternate expiration is listed.

Signatureof Client: _____ Date Signed: _____

Date of Expiration: _____

Notice of Privacy Practices of Therapy Today Counseling & Consulting

Your Information. Your Rights. Our Responsibilities.

This notice describes:

- **HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION
- YOUR RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH PRIVACY OFFICER, LESLIE AULD, AT 517-481-2133 AND leslie.auld@therapytodaycc.com IF YOU HAVE QUESTIONS

In this notice, "health information" includes your psychological and medical record and, where applicable, your substance use disorder patient records protected under 42 CFR Part 2 ("Part 2 records").

Please review this notice carefully.

Your Rights

When it comes to your health information, you have certain rights:

- **Get a copy of your medical record**
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you for as long as the information is maintained in your medical record.
  - We may deny your access to certain health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of this request and denial process.
  - When we approve a release of medical records to you, we will provide a copy or summary, usually within 30 days. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record**
  - You can ask us to correct information you think is incorrect or incomplete for as long as the information is maintained in your medical record.
  - We may deny your request but will explain why in writing within 60 days.
- **Request confidential communications**
  - You can ask us to contact you in a specific way or send mail to a different address.
  - We will agree to all reasonable requests.
- **Ask us to limit what we use or share**
  - You can ask us not to use or share certain information for treatment, payment, or health care operations. We are not required to agree, but if we do, we will follow the agreement except in emergencies.
  - If you pay out-of-pocket in full for a service, you can ask us not to share that information with your health insurer for payment or operations purposes. We will agree unless the law requires us to share it.
- **Get a list of disclosures**
  - You can request an accounting of disclosures of your health information for the six years prior to your request (excluding disclosures for treatment, payment, health care operations, and certain other permitted disclosures).
  - We will provide one accounting per year at no cost upon request; additional requests within 12 months may require a reasonable, cost-based fee.
  - You may also request a list of certain disclosures of your electronic records and a list of health care providers who received your information through certain third parties, as applicable.
- **Get a copy of this notice**
  - You may request a paper copy of the Notice of Privacy Practices of Therapy Today Counseling & Consulting at any time, even if you agreed to receive it electronically.
- **Choose someone to act for you**
  - If someone is your personal representative (e.g., medical power of attorney or legal guardian), that person may exercise your rights.
  - We will verify their authority before taking action.
- **File a complaint if you feel your rights are violated**
  - You may complain to us using the contact information provided on page 1 of this notice.

- You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

200 Independence Avenue, S.W., Washington, D.C. 20201
1-877-696-6775
https://www.hhs.gov/hipaa/filing-a-complaint/index.html

- We will not retaliate against you for filing a complaint.

Your Choices

You may tell us your preferences for how we use and disclose your health information in the following cases:

You have the right and choice to tell us to:

- Share information with family, close friends, or others involved in your care or payment for your care
- Share information in a disaster relief situation
- Include your information in a hospital or program directory

If you are unable to tell us your preference (for example, if you are unconscious), we may share information if we believe it is in your best interest or necessary to reduce a serious and imminent threat to health or safety.

We will **never** share your information without your written permission for:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures
Uses and Disclosures With Your Consent

With your consent, we may use and share your health information to:

- Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for a chronic condition asks another doctor about your health conditions and medications you are taking to avoid complications.

- Run our organization

We can use your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

- Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

With your consent, we may also use and share your information in the following ways:

- Share information with individuals or entities you name
- Prevent multiple enrollments in treatment programs
- Report participation in treatment required by the criminal justice system
- Report prescribed medications to prescription drug monitoring programs, as required by law

You may provide a single consent for future treatment, payment, and health care operations, subject to applicable law.

Uses and Disclosures Without Your Consent
How else can we use or share your health information?

We are allowed or required to share your information in certain ways without your consent – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

To communicate within our practice and with contractors

We can share your information within our practice, with an organization that has administrative control over our practice or a portion of our practice, and with contractors who help us run our practice.

For medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency.

We can also share your identifying information to assist the Food and Drug Administration in notifying you or your doctor about unsafe products you may be using.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medication
- Reporting suspected child abuse or vulnerable and frail adult abuse
- Preventing or reducing a serious threat to yourself or anyone's health or safety

Conduct or assist with research

We can use or share your information to conduct or help with health research. Researchers cannot include any patient identifying information in their reports about the research.

Comply with federal and state laws and oversight activities

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversite agencies for activities authorized by law, including with the Department of Health and Human Services, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with medical examiners, coroners, or funeral directors

We can share information with a medical examiner, coroner, or funeral director when an individual dies and to assist with cause of death inquiries.

Address workers' compensation, law enforcement, and other government requests

We can use or share information about you:

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversite agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Report crimes or threats occurring within our practice or against our staff

We may report to law enforcement when a patient commits or threatens to commit a crime within our practice or against our staff.

Respond to lawsuits and legal actions

We can share health information about you in response to a court order.

Special Protections for Part 2 Records

If we maintain substance use disorder patient records subject to 42 CFR Part 2:

- We will not use or disclose those records in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order and subpoena, as required by law.
- We must follow certain procedures before responding to court orders.
- Redisclosure by HIPAA-covered entities may be permitted for treatment, payment, and health care operations, but your information may not be used against you in legal proceedings without appropriate consent or court authorization.

When you consent to uses and disclosures for all future treatment and payment purposes and to run our business, we may share your information with substance use disorder treatment programs, doctor's offices, and health care businesses for these activities. If the person who receives it is subject to HIPAA, then they are allowed to use and share your information again without your consent for the purposes that HIPAA allows.

In all cases, we will limit the information used or disclosed to what is necessary and protect it as required by law.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We are required to obtain your consent for most uses and disclosures of your information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described here unless you authorize us to. You may revoke your authorization at any time.

For more information about your privacy rights, visit:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We are required to follow the terms of the notice currently in effect. We may change the terms of this notice, and the changes will apply to all information we maintain about you. The revised notice will be available upon request, in our office, and on our website.

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.

This notice is effective as of February 16, 2026.

Signature of Client **Date**

Informed Consent and Authorization for Therapy

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 must be confirmed by your signature.

1. Confidentiality Limits and Expectations

- 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.
- Michigan law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some, but not all, "exceptions to confidentiality" include situations in which there is a reasonable suspicion that any of the following has ever occurred or is occurring now:
  - You or your child present a danger to self or other
  - A child or vulnerable or frail adult is the victim of emotional, sexual or physical abuse, or neglect

2. Limits of Communication

- Every effort will be made to assist you, especially during crisis. However, there may be times when this is not 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.
- If our initial contact was made by email, please note that email and text messages are not secure methods of communicating and I will not discuss clinical material via email 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.

3. Ending Your Therapy or Life Coaching

- 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.
- 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.
- 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. 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.

Your signature below 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.

Signature of Client **Date**

Financial Agreement and Authorization for Insurance Billing

Verification of Insurance Benefit and 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.

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.

Billing Authorization

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.

Payment of Fees

The following fees are client responsibility and are not billable to insurance:

- Written reports requiring more than 15 minutes to prepare and complete are billed to you proportionally at $120.00/hr
- I understand there is a missed appointment fee of **$50** for any no show or late cancellation, less than 24 hours prior to my scheduled appointment. Each client is given one waived missed appointment fee for one emergency with less than 24 hours notice.
- 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.

Signature of Client **Date**

Credit Card Information

Your credit card number will be securely stored on your client portal account 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).

Please choose a payment option:

- ☐ I authorize auto-payments for any copays or Private Pay fees.
- ☐ I authorize auto-payments for all balances at the time of my appointments.
- ☐ I will pay online or at the front desk.

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

Credit Card Number: _____ Expiration Date: _____ Security/CVC Code: _____

Name of Cardholder: _____ Billing Address: _____

☐ Same as Primary Address ☐ Same as Billing Address for Insurance

Signature of Cardholder **Date**

Informed Consent for Teletherapy Services

There are potential benefits and risks of teletherapy that differ from in-person sessions. Prior to starting teletherapy services, and in order to ensure safety and confidentiality, we agree to the following:

- You agree to be located within the state of your therapist's licensure during session in order to comply with insurance and licensing regulations.

- You will need to use a webcam or smartphone during the session so you are visible on screen

- Confidentiality still applies for teletherapy services, and neither party will record the session without the permission from the other person(s).

- We agree to use the teletherapy platform selected for our virtual sessions, TherapyAppointment or Doxy.me, and the therapist or Therapy Today staff will explain how to use it.

- We will establish 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 will establish a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis.

- For minors and children, we require the permission of a parent or legal guardian (and their contact information) for participation in teletherapy sessions.

- 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 appointment, you must notify the therapist in advance by phone or email or call the Therapy Today office at 517-481-2133.

- We recommend you confirm with your insurance company that the teletherapy 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, teletherapy 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.

Signature of Client **Date**