Thriving Lives Counseling

Registration/Intake Form

(Client)Last Name First Name

_____

Home Address

_____

City State Zip

_____

Home phone number cell number work number

_____

DOB Social Security number

_____ _____

E-mail

Insurance information:

Name of insured

Last Name First Name Relationship

_____ _____ _____

DOB Social Security number

_____ _____

Insurance ID number Group number

_____ _____

Insured Address and Phone Number

_____

Name and phone of insurance Place of Employment

_____ _____

Emergency (and/or Guardian) Contact Information:

Unless otherwise specified below, by providing phone numbers and emails you are giving permission for Thriving Lives Counseling, LLC to leave voicemails and contact you via email. For additional information on email communication and privacy, please see our privacy policy.

Name of Emergency and/or Guardian Contact:_____
Relationship:_____
Cell: _____ Home:_____ Work: _____

Optional: Do Not Leave Voicemails on the following phone number(s):

_____

Please use my email address for: ☐Therapist Communication ☐ Clinic updates

Appointment Reminders:

Appointment reminders are provided by our Electronic Medical Records (EMR) system. When your appointment is scheduled, the computerized system is able to send out a reminder 24 to 48 hours in advance. By completing this section, you acknowledge that information through email or text is not necessarily secure and we cannot guarantee that someone else will not access information regarding your appointment through these means.

☐ I prefer not to receive reminders.

If you do prefer to receive reminders, please check the box that applies: (Options below are the options provided by our EMR System).

☐Email Only ☐Text Only ☐Text and Email ☐Text or Call, and Email

If the child has her/his own cell phone and would like a reminder to that phone number as well, please list that number and reminder type below:
Cell: _____ Email: _____

☐Email Only ☐Text Only ☐Text and Email ☐Text or Call, and Email

Additional Contacts: (Optional)

_____

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COORDINATION OF TREAMENT:
It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. If you prefer to decline consent no inform will be shared.

Primary Care Doctor
Name:_____Phone:_____
Address:_____
May we contact this person regarding your care here? ☐ Yes ☐ No

Psychiatrist
Name:_____ Phone:_____
Address:_____
May we contact this person regarding your care here? ☐ Yes ☐ No

Other Professional Contact (ex. school personel)
Name: _____ Phone:_____
Address:_____
May we contact this person regarding your care here? ☐ Yes ☐ No

Financial Responsibility Agreement:
If the Client is a minor (person under the age of 18), it is expected that a guardian or parent be responsible for payment of services. Please indicate the person responsible for payment of the client balance. Please understand that we cannot assign financial responsibility to persons not present to sign this document. Therefore, the person responsible for payment may differ from the insurance holder. If you have any concerns regarding court or custody agreements, please refer to the "Special Circumstances" Section of this document. Thank you.

Party Responsible for Patient Balance: *Person listed must match signature at end of form*
Full Name:_____ Date of Birth: ____/____/____
Gender: _____ SSN: _____ - _____ - _____
Relationship to Patient: _____
Mailing Address:_____
City:_____ State:_____ Zip Code:_____
I understand that by giving this address, statements and necessary forms will be mailed to the address provided

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Other _____

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Payments and Billing:

If you are 18 years of age or older, unless other signatures are provided statements and financial responsibility will default to you.

Billing for services rendered is handled by Thriving Lives Counseling, LLC. Client Statements are sent out once a month to the address provided in the responsible party information section above. For privacy reasons, we do not fax or email statements unless specifically requested as a courtesy. We expect all payments at time of service,

including co-pays, and any co-insurance or deductible to be paid within the billing cycle after your Explanation of Benefits (EOB) is received. To maintain a manageable client balance, you may be asked to pay on your co-insurance or deductible at time of service. We accept payment via pay pal, credit card, cash, or check.

Use of Insurance Plans:

By signing this form, you acknowledge that your insurance coverage, notification of any pre-authorization requirements, and terms of coverage are ultimately your responsibility. This information should be provided to the office before your first appointment. If it is not provided, you understand the risks involved with billing unverified services to the insurance company and may be liable for the full amount of services at the company rate. This requirement is intended for your benefit and allows you to receive the full amount of services available.

If the requirements above are met, but your insurance provider rejects services, you may still be responsible for payment of services provided. If requested, we would be happy to update you on the reimbursements received from your insurance company.

If the Insurance Holder is different that than the Responsible Party previously listed herein, please provide the information here:

Full Name:_____
Relationship to Client:_____

Mailing Address & Apt #:_____
City:_____ State:_____ Zip Code:_____

Date of Birth: ____/____/____ Gender: _____ Phone Number:_____

Cancellation Policy:

By signing this form, you acknowledge that by scheduling an appointment, your provider reserves time specifically for you, your child, or your family. This time is set aside and prevents others from scheduling during your reservation. We request a minimum of 24 hours' notice for any cancellations or reschedules. Because of the time set aside, if proper notice is not given for rescheduling or cancellation, a cancellation fee of $100.00 will be applied to your account. Insurance does not cover missed appointments. Please be aware that a failure to receive a reminder does not waive this cancellation fee. You are still responsible to remember your appointment date and time

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Special Circumstances:
We make every effort possible to respect the wishes of our clients. However, Thriving Lives Counseling, LLC is not responsible for maintaining financial arrangements made between separated or divorced parents or couples under any circumstances. If there is a financial agreement between such parties, we respect your privacy, and require that you manage those arrangements. For financial responsibility in these types of cases, the person whose signature is on file on the registration paperwork is deemed the party responsible for payment. We cannot acknowledge financial responsibility for a party who is not present to agree to the terms provided. (Statements can be provided upon request for proof of payment in order to submit to other parties).

Past Due Balances:
By signing this document, you acknowledge that balances will be automatically be charged to your credit card on file unless other arrangements have been made. If balances are not charged, we reserve the right to utilize collection agency services. We make every effort to work with clients and provide ample time and opportunity for payment. Payments are accepted in person, by mail, and over the phone.

CONSENT TO TREATMENT:
By signing this document, you agree to the following statements:

I agree to participate in treatment and understand that a positive outcome cannot be guaranteed. I understand that working with my practitioner in identifying therapy goals is in my best interest and I agree to be an active participant in working towards these goals. I also understand that there are some instances that therapy could worsen my symptoms, and participation does not guarantee that my symptoms or concerns will be resolved.

CONFIDENTIALITY AND PRIVACY:
I have read and agreed to the Privacy Notice (HIPAA Statement) provided to me. I understand that I can obtain a printed copy from the staff, and can ask for clarification on any policies stated in it.

I (print name) _____ _____have read and understood the above conditions of this document, and agree to them. I have asked any questions I am concerned with and understand the policies outlined above.

x _____ Date:_____
(Signature of Responsible Party)

x _____ Date:_____
(Signature of Client, if 12 years or older)