Lifespan Development Center

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Confidential Registration Form

Client's Name | Date of Birth | Age | Gender

Home Address | Email | Pronouns

City, State, Zip | Best Phone # | Alternate Phone #

_____
If under 18 years old, name of parent(s) or guardian

_____ _____ _____
Name of emergency contact | Phone # | relationship

_____
Name of referring person

Briefly describe the concern or situation that brought you in today: _____

_____

Responsible Party Information

_____ _____
Name of responsible party | Phone # (if different than client)

_____ _____
Address (if different than client)

Payment Authorization

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client.

_____ _____
Today's Date | Signature of Responsible Party

(continued)

Family Information

Number of people in the client's current household: ____ Marital Status of Client: Si M D Sep W
Please list client's immediate family including adult children and those not living with the client.

Names	Gender	Birth Date	Relationship	At Home?	
				yes	no
				yes	no
				yes	no
				yes	no
				yes	no
				yes	no

Languages spoken if other than English: _____

Religious preference (optional) _____

Educational/Occupational Information

Is the client currently a student? □Yes □No Name of last school attended: _____

Highest grade completed: _____ Highest degree and major: _____

Does the client have any learning difficulties? □Yes □No If yes, please briefly describe: _____

_____

Is the client currently □Employed □Unemployed □Retired □Other (please specify): _____

Occupation: _____

Health Information

Name of client's current physician _____ Physician's phone # _____
Is the client currently under a doctor's care □ Yes □ No

If yes, for what reason? _____

List current medications client is taking:

Medication _____ Dosage _____ Prescribed by _____

Medication _____ Dosage _____ Prescribed by _____

Medication _____ Dosage _____ Prescribed by _____

Has client received past counseling or psychotherapy? □Yes □No If yes: When _____

Who did the client see? _____ For what reason? _____

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PSYCHOTHERAPIST – CLIENT SERVICES AGREEMENT

Please review the following practice policies carefully and sign once you understand and agree with its contents.

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. A complete copy is available in the waiting area and on our website for your review. Please ask if you would like a copy of the HIPAA notice. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address which may include psychological assessment. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

APPOINTMENT TIMES

If you are unable to attend a scheduled appointment, please provide my office with 24-hour notification. There is a charge of $100 for appointments missed or canceled without 24-hour advanced notice. This includes appointments missed due to unforeseen circumstances such as traffic, personal emergencies, etc. Exceptions can only be made with the consent of the therapist.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by my assistant or voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have knowledge or reasonably suspect that a child under the age of 18; an elder or dependent adult, has been the victim of physical or sexual abuse or of neglect, the law requires that I file a report with the appropriate governmental agency. I also may make a report if I know or reasonably suspect that mental suffering has been inflicted upon a child or dependent adult or that his/her emotional well-being is endangered in any other way. Once such a report is filed, I may be required to provide additional information...
- If a client or a client's family member communicate that the client poses a serious threat of physical violence against an identifiable victim(s), I must take protective actions, including notifying the potential victim(s) and

contacting the police. I may also seek hospitalization of the client or contact others who can assist in protecting the victim.

- If I have reasonable cause to believe that the client is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. This record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. See complete HIPPA Notice for more details on your rights concerning clinical records.

MINORS & PARENTS

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential, it is usually my policy to request an agreement with minors [over age 12] and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she/they may have.

FEES & PAYMENT

Payment for service is due at each visit. My usual fee is $210 per hour. Therapy sessions are billed at my hourly rate.

Diagnostic Interview	$315	Individual Psychotherapy (50 min)	$210
Full Psychological Assessment	$3045*	Brief Adult ADHD Assessment	$735

** On occasion, supplemental testing may be needed to complete an assessment; additional testing hours will be charged at the current hourly fee.*

I accept cash, checks, MasterCard and Visa. If financial problems arise that affect timely payment of your account, please communicate with me promptly so that we can discuss alternative payment options

INSURANCE

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will provide you with a superbill to assist in getting reimbursement. However, if I am not a preferred provider with your insurance company, you (not your health insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.
Your insurance is a contract between you, your employer, and the insurance company. I am not a party to that contract. Not all services are a covered benefit on all contracts.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT, AGREE TO ITS TERMS AND CONSENT TO TREATMENT. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE DESCRIBED ABOVE AND GUARANTEE PAYMENT OF SERVICES TO LIFESPAN DEVELOPMENT CENTER. IT IS FURTHER AGREED THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

_____	_____	_____
Printed Name of Client/Responsible Party	Signature of Client or Responsible Party	Date

Optional Confidential Credit Card Agreement

I hereby authorize Lifespan Development Center to charge my credit card for all agreed upon services provided to me or my dependent.

Circle One Master Card VISA

Credit Card Number _____

C/C Security Code _____

Expiration Date _____

Billing Address Zip Code _____

Signature _____Date _____

Printed name of card holder _____

Mailing address _____

Phone number _____

Name of **client** (if different than card holder) _____