Inner Resources Counseling
807 **West Broad Street**
Bethlehem, PA 18018

Phone: 610-419-9415 Fax: 610-419-9418

CLIENT REGISTRATION FORM

Date: _____

Therapist: _____ *DX: 1.*_____ *2.* _____

Client Name_____

Date of Birth_____ Age_____

Address _____

Town/Zip _____

Phone: Home_____ Cell_____

Marital Status_____Partner/ Spouse Name_____

If child client: Parents Names:_____

Emergency contact name _____ Number _____

Employer_____Number _____

Do we have permission to contact you and leave a call back message at above numbers? Y or N
Please specify if there are any instructions with regards to contacting you:

_____

How did you find out about us? _____

Physician _____Date of last Physical_____
Permission to contact your PCP: Yes _____ No _____
Major/Chronic Illness:_____

Medications: _____

Previous Counseling: _____

INSURANCE INFORMATON:

Primary Insurance _____ ID# _____
Name of Insured _____
DOB of Insured_____ Social Security of Insured _____
Secondary Insurance _____ID# _____
Name of Insured _____
DOB of Insured_____ Social Security of Insured _____

Inner Resources Counseling
807 **West Broad Street**
Bethlehem, PA 18018

Phone: 610-419-9415 Fax: 610-419-9418

I am thankful that you have chosen me to work with you. This document contains important facts that will provide you with information about fees, appointments, insurance, communication outside of our scheduled sessions, etc. Please read it thoroughly and talk with me about any questions or concerns that you may have.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. There are a few exceptions.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have very rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case, as is standard practice in the field to ensure that clients are receiving the best treatment possible. During consultation, I make every effort to avoid revealing information that could identify my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns that you may have during our next meeting. I will be happy to talk about these issues with you, but formal legal advice may be needed because the laws governing confidentiality are quite complex and I am not an attorney.

APPOINTMENTS

Appointments are typically about 45-55 minutes in length. Though many people begin therapy with the misperception that it is an hour in length, it is important for you to know that appointments are scheduled in hourly time slots, with some time built into that period for me to document the session with notes about our conversation.

Except for rare emergencies, you can expect me to see you at the time scheduled with minimal waiting. Because the time has been set aside for you, it is important that you keep this appointment. It is understood that on occasion, circumstances may arise which require you to cancel. In these cases, please provide at least 24 hours notice.

Failure to provide 24 notice will result in your being billed for the appointment. When appointments are scheduled, it takes this opportunity away from others and, late cancelations and "no shows" prevent us from treating someone else. I am also not compensated, in any other manner, for time lost. Therefore, fees are assessed to you for partial compensation.

TERMINATION OF TREATMENT

The ideal situation for ending treatment is when the therapist and the client agree that the treatment has finished because the client's presenting issues have been resolved. If you feel, for any reason that you wish to end your treatment with me, I ask that you allow us to meet for a final face-to-face session too discuss progress made to date, reason for ending treatment, and resources that you may use to continue your progress. If you wish, I can refer you to another mental health professional at that time.

FEES FOR SERVICE

My service fee is $140 per session. Many insurance companies will cover a percentage of the cost of your treatment. The reimbursement and procedures vary from plan to plan. **Some plans require preauthorization BEFORE your first visit. Please be aware of whether you need preauthorization and be sure that it has been obtained by you or me.** I will assist in any way that I can, including calling for benefit information as a service for you. You are strongly encouraged to confirm this information for yourself, because occasionally I am provided misinformation and payment for counseling services is ultimately your responsibility. If I accept your insurance, then copayment information will have been discussed before we initially meet. Please talk with me about any financial questions or concerns that you have.

Payment is required at the time that we meet. We accept cash, checks or credit card payment. Please note that there is a $2.00 fee for use of credit cards, in session, to help defray costs. Health spending account cards can be used without incurring this fee.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers, so that you are not surprised by uncovered fees. You should carefully read the mental health services sections of your insurance coverage booklet and call your plan administrator about coverage to obtain specific benefit information for yourself.

You should also be aware that most insurance companies require you to authorize me to provide them with a working clinical diagnosis. This information will become part of the insurance company files.

ELECTRONIC COMMUNICATION

Throughout our work together, you may choose to communicate with me utilizing text messaging or by way of email. Electronic communication cannot be considered to be completely confidential or foolproof. We are all aware of situations in which a person's email account or telephone has been compromised in some fashion. Please keep this in mind should you choose to engage in this type of communication with me.

In addition, there are times when an email or text is not delivered promptly by a server and that I may not receive your information immediately. If you have questions regarding this, please discuss them with me.

NOTICE OF PRIVACY AND HIPPA

I understand my privacy and the "Protected Health Information" in the HIPPA information provided and available for reading in the waiting area. I understand billing information (I.E. Diagnosis) may be shared with others who need to arrange payment for my treatment by a third party payer. This office uses professional billing services. I understand if I am concerned about shared information, I have the right to ask for further explanation.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature Date

_____ _____

Treating Therapist Date