
**9045 Forest Centre Drive, Suite 102**
**Germantown, TN 38138**
**(901) 756-5788, (901) 756-8246 (fax)**

# Registration & Patient/Client Information

Name _____ Age _____ Sex _____ Marital Status _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Work Address _____ Work Phone _____

City _____ State _____ Zip _____

Daytime phone number where you wish to be reached regarding appointments _____

Calls will be discreet, but please indicate any restrictions regarding calls: _____

_____

Date of Birth _____ Social Security Number _____

Responsible Party (if other than client) _____

Relationship to Client _____ SS# _____

Who referred you to us? _____ Date problems first noted _____

Date(s) of any previous therapy/treatment _____

Who provided the previous treatment? _____

Who is your primary care physician? _____

Primary Care Physician's Address _____

When was your last comprehensive medical evaluation? _____

Please list any medications you are currently taking _____

*Special Note* _____

**Welcome to HeartLife Professional Soul Care.** *Please read this document carefully* as it contains important information about our professional services and business policies. Jot down any questions you have so you can discuss them with your counselor. Once you sign this it will constitute a binding agreement between us, as well as your consent for us to begin therapy/counseling.

**COUNSELING SERVICES**

We offer services including counseling/therapy for individuals and couples. "Therapy/counseling" is often difficult to describe. However, the type of therapy/counseling we offer is *Bible-based and Christ-centered.* It is important for you to understand that *we operate from a Christian perspective*. This perspective views man and his problems from a Biblical "World View"; therefore, solutions offered will be based on this position. If there are any questions about our approach, please ask them during the first meeting.

As counselors we do not provide any medications or perform any medical treatments. If medication seems indicated, we maintain close working relationships with a number of physicians and psychiatrists, and we will gladly refer you to these practitioners.

One potential benefit of therapy/counseling is the ability to detect, challenge, and change those beliefs and attitudes that create, maintain, and worsen conditions such as depression, anxiety, panic, anger, frustration, etc. *Christ-centered* therapy/counseling can help us gain new understanding about our problems and learn new ways of applying God's Truth to our lives.

Sometimes there are potential risks when entering any therapy/counseling relationship. Some people may experience some degree of discomfort, feelings of sadness, anxiety, frustration, etc., when working through difficult issues. Some may recall unpleasant aspects of their life and at times, report feeling worse before feeling better. Our desire is for people to be strengthened individually and in their relationships.

We will regularly review with you your goals and progress, and want you to be open and honest in providing input or suggestions. At any time during our work together, you have the right to decide to end treatment, and there is no moral, legal, or financial obligation other than to pay for the services already rendered. If you are thinking about ending therapy/counseling, we encourage you to discuss this with us and, if you wish, we will provide you with the names of other mental health providers.

**MEETINGS**

During our first meeting we will conduct an evaluation. We often refer to this as a "fact finding mission." We will take a history and together we will develop a plan to meet our treatment objectives. At the end of our first meeting, it should be clear to you and your counselor if he/she is the best person to help meet your objectives. Please feel free to ask any questions so that your decision to work with your counselor is as informed as is reasonably possible. Our sessions are **50 minutes**, although extended appointments are available. **Unless 24 hours notice is given, you will be expected to pay for the missed appointment (full session charge) unless the office manager excuses payment due to circumstances beyond your control. _____** *(initials).* Our office needs this notice to fill any vacant appointment times with other clients on a waiting list. In the event of extremely bad weather such as ice and snow, is it advisable to call just to make sure the office is open.

**TELEPHONE CALLS/EMAIL**

We strive to return telephone calls as soon as possible. We are not interrupted during sessions for incoming calls unless it is an emergency. **The telephone is not the best means with which to deal with therapy/counseling issues, and telephone calls may be charged at the normal rate.** In certain situations however, you may feel a phone consultation necessary. If so, we will charge our normal therapy/counseling rate. In the event of a life-threatening emergency, it will be necessary for you to call 911. Discuss email with your counselor. If your counselor agrees to email, your signature below indicates that you understand that information exchanged via email cannot be guaranteed confidential.

*I give permission for my counselor to email me _____ (initials) at _____ (email address)*
*I do not wish to have any information exchanged via email _____ (initials).*

**PROFESSIONAL FEES**

Please check with our Office Manager for individual, group and couples/family fees lasting 50 minutes. As noted, fees for telephone consultations will be billed as a therapy session. *Our office does not file insurance claims*. However, if you request that we provide information to your insurance company (MCO), we reserve the right to charge for the time involved. Such charges will be based on the session fee. Please indicate your understanding that we **do not** participate in managed care contracts _____ (*initials).* We will provide you with the necessary information should you decide to file.

**LEGAL INVOLVEMENT**

It is important to note that HeartLife professionals work toward relational reconciliation which is why we have you agree to sign this **Registration Form** agreeing to not depose us. Should this agreement be ignored, and we become involved in any legal matter via court order or deposition, our standard fee is $150 per hour to review case files, talk with clients/patients, or attorneys in addition to the fee of $1000 detailed below. Should we be deposed or ordered to testify, a fee of no less than $1000 (some clinicians will charge more) is required for testimony or deposition per day. This fee of $1000 applies to a full or partial day due to the fact that our scheduled clients/patients must be rescheduled.

All fees are subject to change, and in the event of fee changes, you will be notified as least 30 days prior to such changes. There is a $20.00 service charge on all returned checks.

**BILLING AND PAYMENTS**

**You will be expected to pay for each session at the time it is held _____** *(initials).* As previously stated, we do not participate in managed care organizations (MCO). To do so could compromise our commitment to Christian counseling. We will be glad to discuss this with you. Payment schedules for other professional services will be agreed to at the time these services are requested.

Please remember that we have a professional relationship with you and not with your insurance company. Fees are charged to the client, and we cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. **You are responsible for your bill** regardless of the action of your insurance company. Balances may not exceed $150.00 after a 30-day billing cycle, unless arrangements have been made in advance.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment including mediation, arbitration, collection agencies, or court. Further, upon nonpayment, we also reserve the right to report the "bad debt" to relevant credit bureaus. If such action is necessary, the costs of bringing that proceeding will be included in the claim, and the client or responsible party will be responsible for all costs of collection, etc. In such cases, the only information that is released about a client's treatment would be the client's name, the nature of the services provided (e.g., individual therapy), dates of services, and the amount due.

The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits which sometimes makes it difficult to determine exactly how much mental health coverage is available. Additionally, "managed health care plans" such as PPOs and HMOs often require advance authorization before they will provide reimbursement for mental health services. Many such plans emphasize "brief" or "short-term" therapy. If you choose to use a provider who is a member of your MCO, be advised that they may not counsel from a biblical or Christian perspective. **Please note the following:**

Insurance companies and managed care companies almost always require outpatient treatment plans or reports as a condition for certifying or re-certifying treatment. Information requested may be as simple as a diagnosis and type of treatment but may also be of a personal nature requiring more detailed information. Some companies have even requested a copy of the entire record. This information will become part of the insurance company files, some of it may be computerized. All insurance companies/managed care companies claim to keep such information with a national medical information data bank (such as the MIB – Medical Information Bureau). Because of the potential for loss of privacy, some clients prefer not to file insurance claims.

**CONFIDENTIALTY**

Within the limitations discussed below, the information you reveal to your counselor during the professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached including: (1) if you present a danger to yourself; (2) if you present an imminent danger to another person, which can include a communicable disease that can be life-threatening to others; (3) if there is reason to believe that child abuse or neglect is present or has been present, a report must be filed with a state child protection agency (elder abuse applies as well); (4) if a legitimate court order is issued; (5) if the treatment is ordered or under the supervision of the court; and (6) as discussed above, an insurance company or a managed care company requires you to consent to release records and/or information to them as a condition for reimbursement. When such is released, *we cannot control how the information is treated, nor will we be responsible for any injury or claim for damages arising from the release of records or information you request to be released to the insurance company or managed care organization.* No clinical/counseling information is revealed to our staff other than information that you provide when calling or presenting for appointments. We have discussed the legal and professional necessity of confidentiality with our staff.

Information revealed in marital therapy is protected by privileged communication in Tennessee and requires permission of both parties to waive. When working with couples, we adopt a "**no secrets**" rule. That is, should your counselor speak individually with either party (e.g., via telephone), he/she reserves the right to disclose any information to the other party if he/she believes such information is relevant to the therapy/counseling process.

***Special Note***: Because of our Christian perspective, we encourage reconciliation when relationships are damaged. When a family is confronted by parental separation or divorce, it is very hard on everyone. It is important when working as a couple, each person feels safe to speak openly and honestly, without fear that material revealed in therapy will be revealed in court and used in a negative fashion. In order to provide a safe environment for couples work, it is important that you agree ***not to call your counselor as a witness nor attempt to subpoena counseling records.***

In order to provide coverage when your counselor is out of town, it may be necessary for him/her to release general information to the licensed counselor on call. If an emergency requires your counselor to be out of the office suddenly, we will be guided by the American Counseling Association's Ethical Principles and Code of Conduct regarding the type of information disclosed. *Your counselor is under the direction of the Executive and Clinical Directors. Your signature below indicates that you understand and agree that your counselor may share information regarding your case for consultation and oversight. Any information related to the Executive or Clinical Director will be protected as described above _____(initials).*

As noted earlier, if because of nonpayment of your bill we pursue legal remedies, certain information will not be considered confidential and will be released, but this would be limited to the minimum that is necessary to achieve the purpose.

**AGREEMENT**

I have read this information fully and completely, I have discussed any questions I have about the information, and I understand the information. I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy/counseling. I have familiarized myself with the fees and charges for services provided by HeartLife Professional Soul-Care and I understand and agree that the counseling services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of services, and I understand I am responsible for all costs of collection and litigation, including attorney's fees. If I consent and agree that HeartLife Professional Soul-Care may release information, as requested by me, to my insurance company and/or managed care company for services rendered, I agree to hold HeartLife Professional Soul-Care harmless for any injury or claim for damages arising from release of records or information as I request to my insurance company/managed care company.

Client (s) _____ Date _____

Responsible Party/Guardian _____ Date _____

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# CLIENT/PATIENT NOTIFICATION OF PRIVACY RIGHTS

**The Health Insurance Portability and Accountability Act (HIPAA) has created new client/patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client/patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client/patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care; and providers and health care agencies throughout the country are now required to provide clients/patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.**

**As you might expect, the HIPAA law and regulations are extremely detailed and often difficult to grasp if you don't have formal legal training. Our Client/Patient Notice of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document since it is important you know what client/patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, we will do all we reasonably can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.**

**By law, we are required to secure your signature indicating you have reviewed this Client/Patient Notification of Privacy Rights Document, and have been offered a copy of the document, if you so desire. Thank you for your thoughtful consideration of these matters.**

**I, _____, understand and have reviewed a copy of HeartLife Professional Soul-Care's Notice of Privacy Practices (NPP) which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form, and that a copy of this document is also available upon request.**

_____ _____

**Client(s)/Patient(s) Signature(s)** **Date**