Counseling Associates of the Four States, LLC
705 W. 26th Joplin, Mo 64804
417-627-9994

**Registration Form:** **DATE:**

***Please fill this information out for the person being seen as the CLIENT today.***

## CLIENT INFORMATION:

Client name_____ Age_____
Birth Date_____ Social Security # _____
Marital Status: *(circle)* M D S W Gender: Male/ Female
Address _____
City_____State_____Zip _____
Home Phone _____ Call Y/N Voicemail Y/N
Cell Phone_____ Call Y/N Voicemail Y/N
Email _____ Ok to Email? Y/N

***Appointment Reminders are done via text message if you are unable to receive text's please inform us at the window. Thank you!***

Place of Employment: *(Insurance Purpose)*

_____
Work Phone_____ OK TO CALL? YES / NO

How did you hear about us? Website Facebook Friend Other_____

***Please fill this portion out if the above client is a minor or there is another responsible billing party.***

## SPOUSE/ PARENT or GUARDIAN INFORMATION:

Name _____ Age _____
Birth Date_____ Social Security #_____
Marital Status*(circle)* M S D W Gender: Male/ Female
Relationship to Client:_____
Address _____
City_____ State _____Zip _____
Home Phone _____ Call Y/N Voicemail Y/N
Cell Phone _____ Call Y/N Voicemail Y/N
Email _____ Ok to Email? Y/N

**Appointment Reminders are done via text message if you are unable to receive text's please inform us at the window. Thank you!**

Place of Employment: *(Insurance Purpose)*

_____
Work phone _____ OK TO CALL? YES/NO

**Other Parent Info:**

Name: _____ Phone:_____
Place Of Employment: _____

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# Financial Terms and Insurance Coverage

**Cancelled, Missed, and Late Appointment Policy:** Counseling Associates is committed to providing all of our clients with exceptional care. When a client cancels without giving enough notice, they prevent another client from being seen at this time. **Please call or text our office by 2 pm on the day prior to your scheduled appointment to notify us if you're unable to keep the appointment. For Monday appointments, please call our office by 2 pm on the Friday before**. If prior notification is not given, you will be charged a minimum of $25 for a late cancellation and $75 for a no show appointment. If you LC or NS three or more scheduled appointments, there's a potential that you won't be able to reschedule. Please be advised that your counselor is typically scheduled every hour, if you are more than 15 minutes late for your scheduled time it may not be possible for you to be seen that day.
**Initial here:_____**

**Delinquent Accounts:** You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay the actual balance due plus any collection expenses incurred to collect that balance. Extra fees will include a $5.00 statement fee per billing cycle for balances left unpaid over 30 days, any attorney fees associated with the collection of delinquent accounts and any court fees.
**Initial here:_____**

**Insurance:** You are responsible for obtaining any necessary prior authorization for treatment from your insurance carrier. Your therapist may bill your insurance as a courtesy by prior arrangement; however, you are responsible for the entire agreed-upon fee, regardless of insurance coverage or lack thereof. At any time during treatment should you become ineligible for insurance coverage, you will notify the therapist and understand you will become responsible for 100% of the bill. **Insurance verification is done as a courtesy and is NOT a guarantee of benefits. Benefits are determined once a claim has been processed and we receive the explanation of benefits (EOB).**
**Initial here:_____**

**Court Related Services:** If your counselor is served a summons to appear in court on your behalf or that of your minor child, you will be responsible for compensating your counselor for their *time* required to prepare, travel and time spent in court. This includes time waiting to be called into court. You are not paying for testimony. The rate for court services is **$500 for preparation time and $150.00 per hour of court appearance with a minimum of one hour. Additional fees may be incurred as necessary**. In lieu of attending court, if your counselor is asked to provide written summary of progress notes or phone consolation with your attorney, you will be charged a minimum of $150. If only copies of records are requested and NO APPEARANCE, there will be a flat fee of $20.00 plus $0.50 per page plus postage if necessary. Any charges related to court are due prior to your court date.
**Initial here:_____**

These notes have been prepared so that you will have an understanding of our basic agreement.
*Counseling Associates of the Four States, LLC is owned by Deanna Street, MA, LPC. Each affiliate/therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from his or her practice.*

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# The Process of Therapy

**Risks and Benefits:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will expect you to respond openly and honestly. During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed.

Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and their assessment of what will best benefit you. Their approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, development, or psycho-educational techniques.

**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives and their view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, your therapist has an ethical obligation to assist you in obtaining these treatments.

**I have read the above statements:_____**

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# Agreement for Counseling Services

Because therapy often begins in a situation of considerable emotional difficulty, your therapist has an ethical obligation to assist you in obtaining these treatments.

**Terminating Treatment:** You always have the option to terminate treatment at any time, for any reason. It is customary to discuss this with your therapist in session, so that any concerns either you or your therapist have may be adequately addressed. If your therapist feels that therapy is not benefiting you, your therapist will also discuss this with you.

**Telephone and Emergency Procedures:** If you need to contact your therapist between sessions, please leave a message with the office staff and your call will be returned as quickly as possible. If an emergency arises, please report to your local hospital emergency room or call local law enforcement. If you need to talk to someone right away, or if there is a life-threatening emergency, please call 911.

**Signed**_____ **Date**_____

Counseling Associates of the Four States, LLC would like your permission to allow another licensed professional, provisionally licensed professional, or intern to attend sessions as an observer and/or co-counselor. This will also be used in order to teach techniques used during sessions. The information will be kept confidential and will only be used as a training tool. All observations/co-counselors are mental health /medical providers. This practice will only be done with your written permission and only in the capacity addressed. If you have any questions regarding this authorization, please ask. This is strictly voluntary and may be revoked at any time.

____ I **DO** agree to allow an observer/co-counselor to attend sessions

____ I **DO NOT** agree to allow an observer/co-counselor to attend sessions

_____ _____
Signature Date

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# Insurance Release

*I understand that I am financially responsible for the payment of all charges for services regardless of insurance coverage or other third party coverage unless prohibited by State or Federal law or regulations. I understand that I am responsible for any non-covered deductibles, copays and coinsurance as outlined in my plan. In addition I assume responsibility for pre-certification or pre-authorizations. I understand the benefits provided to me by the staff of Counseling Associates in not a guarantee of benefits but only an estimate of benefits obtained via phone call to the number on the back of the card provided by myself. Guaranteed benefits are only determined at the time claims are processed. By signing I acknowledge that I have read these statements and the information submitted is true and correct to the best of my knowledge. I acknowledge that this information has been explained to me to my satisfaction and that if I am not the client of Counseling Associates of the Four States, LLC, that I am the Guardian or parent of the client and therefore legally authorized to sign on their behalf.*

***Medicaid***
Signed:_____**Date**:_____
I authorize direct payment and grant permission to collect all benefits applicable to my treatment to Counseling Associates of the Four States, LLC .

***Medicare***
Signed:_____**Date**:_____
I authorize direct payment and grant permission to collect all benefits applicable to my treatment to Counseling Associates of the Four States, LLC .

***Insurance***
Signed:_____ **Date**:_____
I authorize direct payment and grant permission to collect all benefits applicable to my treatment to Counseling Associates of the Four States, LLC .

***Secondary Insurance***
Signed:_____ **Date**:_____
I authorize direct payment and grant permission to collect all benefits applicable to my treatment to Counseling Associates of the Four States, LLC .

***EAP/ Other***
Signed:_____**Date**:_____
I authorize direct payment and grant permission to collect all benefits applicable to my treatment to Counseling Associates of the Four States, LLC .

***Self Pay***
Signed:_____**Date**:_____
I understand that payment is due at time of service and paid directly to Counseling Associates of the Four States, LLC .

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# HIPAA Privacy Notice

**Client Name:** _____ **Date:** _____

As a person receiving services from **COUNSELING ASSOCIATES OF THE FOUR STATES, LLC** you have rights concerning the protected health information that is collected and used to provide these services.

## Clients Rights

You must give your permission for certain people outside of the above named agency to see your health information.

- You make revoke this permission by filing a written form.
- When children are in the Children's Division custody, Children's Division staff has the same authority as parents with regard to disclosure of health information.

You can request to see or copy your health information.

- You may be denied access to certain parts of your health information.
- You may appeal to the above named agency's Privacy Officer if access to parts of your health information is denied.

You can request that changes be made in your health information.

- The request may be made to the above named agency's Privacy Officer.
- The request may be either granted OR denied.

You can request that certain parts of your health information not be shared with others.

- The request may be made to the above named agency's Privacy Officer.
- The request may be either granted OR denied.

The above named agency must let you know when the above named agency shares your health information with others

You may contact the above named agency's Privacy Officer at above address/phone number

## The Above Named Agency Does NOT Need Authorization when:

The above named agency does NOT need authorization to share your health information with others:

- To make Child Abuse/neglect reports, and to respond to requests concerning child abuse/neglect investigations
- When a Court Orders the above named agency to share your health information.
- To make your health information available to Judicial or Administrative proceedings under certain circumstances.
- If police need certain information from your health information available.
- To help keep someone else safe.

## Complaints

If you believe that the above named agency and/or its representatives have improperly used or disclosed your Private Health Information, or that the above named agency is not complying with the requirements of HIPAA, you may file a complaint with one or both of the following:

- Missouri Department of Social Services Complaint Officer, P. O. Box 1527, Jefferson City, MO 65102-1527.
- Secretary of the Department of Health and Human Services, 200 Independence Avenue –SW, Washington, DC 20201.

*Do you understand this policy?* ☐ *Yes* ☐ *No*

| | | | |
|---|---|---|---|
| **Client Signature** | Date | **Parent /Legal Representative Signature** | Date |