FAMILY COUNSELING ASSOCIATES, INC.

PATIENT REGISTRATION

PATIENT NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____

CITY: ______________________________STATE: ____________ ZIP: ____________

EMAIL: ______________________________ CELL PHONE: ______________________

GENDER: __________ DATE OF BIRTH: _____/_____/_________ AGE: __________

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER : XXX-XX-___ ___ ___ ___

IF STUDENT, NAME OF SCHOOL: ______________________________ GRADE: __________

INSURANCE POLICY HOLDER NAME: ______________________________ DOB: _____/_____/_____

PARENT/ GUARDIAN (IF PATIENT IS A MINOR): ______________________________

CONTACT NUMBER FOR PARENT/ GUARDIAN: ______________________________

EMERGENCY CONTACT NAME: ______________________________

PHONE NUMBER:______________________ RELATIONSHIP: ______________________

BEST CONTACT NUMBER TO REACH PATIENT AND LEAVE VOICE AND/OR TEXT MESSAGES: ______________

NAME OF CONTACT (IF PATIENT IS A MINOR): ______________________________

OFFICE POLICIES REGARDING INSURANCE AND BILLING

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

It is your responsibility to pay any deductible amount, copay, co-insurance amount or any other balance not paid by your insurance at the date and time services are provided. There will be a $25 service charge on all returned checks. In the event your account goes to collections, there will be a 20% fee added to your balance. ____________ INITIALS

CONSENT TO TREATMENT

I hereby authorize Family Counseling Associates, Inc. to administer mental health / psychiatric treatment. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that Family Counseling Associates, Inc. may be obligated to release information to my insurance company from my medical records as determined and required by my company's guidelines and hereby authorize the release of such information. I authorize the release of pertinent information for collection purposes should it be necessary. I hereby consent to receive consumer survey material following completion of treatment for purposes of evaluating my satisfaction with and the effectiveness of services rendered by Family Counseling Associates, Inc.
____________INITIALS

FOR MINORS: I represent and warrant that all information submitted is true and correct and that I have complete and proper authority to involve the above referenced minor patient for treatment at Family Counseling Associates, Inc. I understand that Family Counseling Associates, Inc. is relying upon my representation to accept the minor child as a patient and I shall hold harmless and indemnify Family Counseling Associates, Inc. as the result of any representations which are not true and correct.

_____________ INITIALS

POLICIES AND PROCEDURES

Family Counseling Associates, Inc. maintains the highest professional and ethical standards. In order to serve our clients to the best of our ability, we request that you review the following policies and procedures prior to your initial sessions. Should you have any questions or concerns prior to signing acknowledgment of these terms, please discuss these issues with your therapist.

Emergency Services: Family Counseling Associates, Inc. does not provide 24 hour emergency coverage. Should you have a potentially suicidal/ homicidal situation, please CALL 911 IMMEDIATELY or go directly to the emergency room of the nearest hospital based on the severity of your situation. You may also contact the Mobile Crisis Team 24 hours a day/ 7 days a week if you are experiencing a clinical emergency at **561-383-5777.** _____________ INITIALS

Confidentiality of Relationship: All information given by you or your family is treated as confidential and may be released only upon your written consent or as required by law. The legal limitations to confidentiality include: Suspected or reported child abuse/ neglect, suspected or reported situations which your therapist believes to be potentially life threatening to you or others, or should a court order require your therapist to provide information to the courts. _____________ INITIALS

Canceled / Missed Appointments: <u>**Appointment reminders are given as a courtesy only. You are ultimately responsible for remembering appointments you have made.**</u> Appointments must be canceled no later than 24 hours (the day before) of your scheduled appointment. We reserve the right to charge a fee for failed appointments. Your insurance company will not pay for missed or failed appointments; therefore you are responsible for this fee. _____________ INITIALS

Phone Contacts: Your therapist will make every effort to be available for brief phone contact. Lengthy phone calls, consultations, and correspondence may be billed at your therapy rate. Should you wish to have a phone session, please consult with your individual therapist. Most insurance companies do not cover phone sessions. _____________ INITIALS

Court Testimony: We do not believe it is advantageous to expect your therapist to testify in court. The only exception to this is if you are here originally for an evaluation regarding a legal issue. All forensic work (e.g. depositions, testimony, court reports, research, correspondence, etc.) will be billed at the rate of 200% of our therapy fee. _____________ INITIALS

Session: Please respect that your sessions are scheduled for 45-50 minutes. Most insurance companies pay for a 45 minute sessions. We ask that you arrive for your session on time. Your session will be limited to the original scheduled time. Should your therapist be responsible for a session starting late, you will receive your entitled session time. _____________ INITIALS

INSURANCE WAIVER

All services that we provide to you in our office will be billed to your insurance company. Any services not paid by your insurance will be your responsibility. Due to the magnitude of changes within the insurance industry, we are unable to pre-verify benefits for all insurance, as many companies subcontract their outpatient mental health benefits. You need to be aware of your own insurance benefits and what will be covered by your plan. It is your responsibility to obtain prior authorization if it is required by your insurance company. In addition, it is your responsibility to inform the office of any changes to your insurance coverage immediately.

_____________ INITIALS

HIPAA SIGNATURE

I acknowledge receipt of the HIPAA notice of Privacy Practices and the Office Policies and General Information agreement for psychotherapy services. This signature page will be placed in your medical chart. Should you have any questions, please address them with our office staff or your individual therapist. _____________ INITIALS

I hereby acknowledge that by signing below I accept and understand the above Office Policies Regarding Insurance and Billing, Consent for Treatment, Policies and Procedures , Insurance Waiver and HIPA Signature.

____

Signature of Client (or Parent or Guardian) Date

____

Name of Client (PLEASE PRINT) Date

____

Witness/ Therapist Signature Date

FAMILY COUNSELING ASSOCIATES, INC.
4425 MILITARY TRAIL, SUITE 203
JUPITER, FL 33458 (561)747-2775

CONSENT FOR PRIMARY CARE PHYSICAN (PCP) CONTACT

At Family Counseling Associates, Inc., we strive to provide our clients with the most comprehensive treatment possible. We feel your care is enhanced when it is coordinated with the services provided by the practitioners involved in your physical health services (e.g. Primary Care Physicians (PCP), psychiatrists, etc.) This allows for a continuum of care between the professionals who are committed to your care and well-being.

If you direct us to do so, we will send a letter to the physician of your choosing. This letter will simply state that you have been seen in our office for mental health services. No details of your visit will be released.

If at any time in the course of your treatment you or your therapist feel it would be advantageous to share your case details with another person / doctor, you must complete and sign a Records Release Form. These are available in our office and your therapist can give you more information.

DO YOU WANT US TO SEND THE LETTER DESCRIBED ABOVE TO ANOTHER PRACITIONER?

CHOOSE ONE: **YES** **NO** **(SIGN BELOW)**

IF YOU CHOSE "YES" PLEASE PROVIDE THE FOLLOWING INFORMATION THEN SIGN BELOW:

Name of Physician / Psychiatrist: ______________________________

Telephone Number: ______________________________

Secondary Physician: ______________________________

Telephone Number: ______________________________

PLEASE SIGN, DATE AND PRINT YOUR NAME BELOW:

____

PRINT NAME OF CLIENT CLIENT'S DOB

____

SIGNATURE DATE OF SIGNATURE