REGISTRATION FORM

(Please Print)

PCP:	**(For office use only)** Diagnosis Code:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Home phone #. : ( )	Cell phone #.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Psychology Today	☐ Internet	☐Other

Email Address:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]

☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ Medicaid #	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Connecting Dots Counseling Services

810 Dutch Square Blvd, Suite 484| Columbia, SC 29210 Office: 803.798.2228 | Fax: 803.798.2229

OUTPATIENT SERVICES CONTRACT

For best results and your own welfare, it is important that you understand what it means to be in counseling. Please read the brief description below. If you have any questions or concern, you are urged to talk about them. If you understand it and you choose to be in counseling as described here, initial each point and sign and date this form. Your signature represents an agreement between us.

1. Counseling is a special kind of health care service. The goals of counseling are to help you better understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help you better cope with the feeling and challenges that you encounter in your daily life. **I understand: ____yes ____no**

2. The most common form of counseling involves you talking about your feelings, your problems or concerns, and your experience of yourself and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home.
   I understand: ____yes ____no

3. To better understand you, many counselors use a variety of tests or measures of your current abilities and styles of experiencing. These measures are important in choosing the treatment methods best suited to you, and they are helpful in estimating your progress. **I understand: ____yes ____no**

4. The length of counseling depends on your individual needs and the rate of your progress. Many therapists use periodic reviews as a means of evaluating your needs and the rate of your progress, and satisfaction. **I understand: ____yes ____no**

5. Most people benefit from counseling. The most common benefits include improvements in self awareness, self-esteem, self-confidence, hope, feelings understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in counseling. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by counseling is rare, but you should be aware that it could happen. The most common cause of such damage is poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in counseling in any way – financially, physically, sexually or otherwise - you should inform the state agency responsible for professional licensing. **I understand: ___yes ___no**

6. You always have the right to choose whether to continue in counseling. If you feel you might work better with a different therapist, your present therapist should be able to offer you information on possible referrals. Local mental health agencies are listed in the phone book and they may also

offer helpful information. The most common alternative to counseling is self-help/support groups and bibliotherapy (therapeutic reading). **I understand: ____yes ____no**

7. The information communicated in therapy must be kept confidential by your therapist unless you grant permission to release it. State laws dictate the only exception to this protection of your privacy.

<u>Confidential information may be released WITHOUT your permission if:</u>

- You threaten to harm yourself or someone else and your threat is believed to be serious, your therapist is ethically and, in some instances, legally obligated to take whatever action deemed necessary to protect you or others from harm.

- There is suspected child abuse or neglect. Therapist is obligated by law to report this to the appropriate state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting a child.

- You are in court-ordered therapy; you can assume that the court wishes to receive some type of report or evaluation.

- You are involved in litigation of any kind and inform the court of the services you receive here (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waving your right to keep your records confidential.

- You lodge a formal complaint against me or make me a party of a legal action.

- You use insurance to reimburse for mental health services.

- You do not pay your bill and billing information is forwarded to a collection agent.

I understand these limits of confidentiality: ____yes ____no

8. I understand that my therapeutic relationship is with Katrina Williams MA, LPC, LPC-S. Although the location is at 810 Dutch Square Blvd, Suite 484, Columbia, SC 29210. **I understand: ____yes ____no**

Your signature below indicates that you have read and understood the above description of counseling. Your signature also indicates that you are now consenting to be in counseling with the understanding that you retain the right to review and revise this decision at later points in time.

_____ _____

Signature of Client or Parent/Guardian Date

South Carolina provides the consumer the opportunity to file inquiries with the Board of Examiners for Professional Counselors. Board office may be reached at South Carolina Board of Examiners for Professional Counselors, P.O. Box 11329, Columbia, SC 29211-1329.

PROFESSIONAL DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT WITH KATRINA WILLIAMS, MA, LPC, LPC-S

I acknowledge that I have received and read the Professional Disclosure Statement and Consent for Treatment with Katrina Williams, MA, LPC, LPC-S and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment, with information, for the purposes of treatment, payment, and health care operations as described in the HIPAA Client's Rights. My signature below confirms that I understand and accept all the information contained in the *Professional Disclosure Statement and Consent for Treatment with Katrina Williams, MA, LPC, LPC-S and the HIPAA Client's Rights.*

_____ _____

Signature of Client or Parent/Guardian **Date**

Patient Rights & Responsibilities

- Patients have the right to be treated with personal dignity and respect.

- Patients have the right to confidentiality of information (note exceptions in “Consent to Treat” Form).

- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.

- Patients have the right to individualize treatment, including
  - Provision of service within the least restrictive environment possible. - An individualized treatment or program plan.

- Patients have the right to voice complaints or appeals about managed care company or the care provider.

- Patients have the responsibility to give their provider and manage care company information needed in order to receive appropriated care.

- Patients have the responsibility to follow their agreed treatment plan and instruction for care.

- Patients have the responsibility to participate, to the degree possible in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.

I have read and understand this document.

_____ _____

Signature of Client **Date**

Privacy Notice Your Rights as a Therapy Client under HIPAA (Health Insurance Portability & Accountability Act)

- As a client, you have the right to see your therapy file. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.*

- As a client, you have the right to receive a copy of your therapy file. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.* (You would be required to pay any copying fees at a rate of $10.00 and $15.00 clerical fee.)

- As a client, you have a right to request amendments to your therapy file.

- As a client, you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment, and operation. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

- As a client, you have the right to receive a copy of this Privacy Notice upon your request.

- As a client, you have the right to register a complaint if you feel your rights herein explained, have been violated. Complaints or questions regarding your privacy rights should be directed to **South Carolina Board of Examiners for Professional Counselors, P.O. Box 11329, Columbia, SC 29211-1329.**

Connecting Dots Counseling Services, LLC

810 Dutch Square Blvd, Suite 484, Columbia, SC 29210

Office: (803) 798-2228 | Fax: (803) 798-2229

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize **Connecting Dots Counseling Services**

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization apply to:

- ☐ Healthcare information relating to the following treatment, condition, or dates: _____

  _____

- ☐ Other:_____

- ☐ Yes I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

- ☐ No I do not authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

FEE INFORMATION AND AGREEMENT

Professional fees are based on the standard 45-60-minute session at $120.00 for the initial session and $100.00 for follow-up sessions. Unless otherwise discussed, you are expected to pay the standard fee at the time services are rendered. Please speak with me about any concerns regarding fees or payment of fees.

Since professional services are available through prior scheduling, non-attendance at sessions without 24-hour notice or sessions canceled or rescheduled with less than 24 hours' notice may be billed at the same rate or the schedule service. Extenuating circumstances are taken into consideration.

Phone consultations 15 minutes and longer and emergency phone calls are subject to billing. Consultations with attorneys, court preparation, and travel time are billed at $150.00 per hour or quarter hours thereof.

INSURANCE

Insurance may or may not pay for your therapy. If you choose to seek third party reimbursement, you are responsible for contacting your insurance carrier and inquiring about their coverage and procedures for filing reimbursement. I will file insurance as a service to you, unless you decided to file yourself. In some cases when I am not on your insurance provider list, you might ask them about their reimbursement percentage of "Out of Network Providers" or about an arrangement for the provider of your choice.

I, _____, understand and agree to pay Connecting Dots Counseling Services the amount of $_____ before each **45-60** minute counseling session.

I understand that I am responsible for payment for sessions not canceled 24 hours in advance with the exception to extenuating circumstances (e.g. sickness or death in family, etc.). I hereby authorize the therapist to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments.

All decisions to file with insurance should be discussed in detail with me due to the disclosure required by insurance companies for reimbursement.

I, _____, understand that services are delivered by Katrina Williams in good faith and that payment will be made in accordance with the information listed above.

_____ _____

Signature of party responsible for payment Date

_____ _____

Katrina Williams, MA, LPC, LPC-S Date

CONNECTING DOTS COUNSELING SERVICES

NO-SHOW/CANCELLATION POLICY

Our office requests a 24-hour notice of an appointment cancellation. If a notification was not made, there will be a $35.00 fee added towards the future appointment. This fee is expected to be paid before being seen by the therapist.

When (3) No-Shows/Cancellations have been accumulated within a calendar year, the client will be discharged from the practice.

Please help us to better serve you and other clients by keeping all scheduled appointments.

I certify that I have read and understand the "No-Show/Same Day Cancellation Policy" and agree to all terms and conditions as stated above.

Print Name: _____Signature: _____Date: _____