Client Registration Form

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ AGE: _____

MARRITAL STATUS: _____

LAST 4 DIGITSOF SOCIAL SECURITY#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ OCCUPATION: _____

PLACE OF EMPLOYMENT: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: CELL PHONE: _____

DO WE HAVE PERMISISON TOTEXT YOU TO COMMUNICATE? YES NO

Email Address:

HOW DID YOU HEAR ABOUT US? _____

Insurance Information:

Client Information						**Insured Information** (if different from client)			
Client Name:						Insured Name:			
Client Date of Birth:						Insured Date of Birth:			
Client	SS#:					Insured SS#:			
Client Address:						Insured Address:			
Client	Phone Number:					Insured Phone Number:			
Client	Employer:					Insured Employer:			
Client Marital Status: Single Married			Other			Insured Marital Status: Single Married		Other	
Employment Status:		PfT		FfT	Retired	Employment Status:	PIT	FfT	Retired

Relationship to Client:

Primary Insurance:

Address for Claims:

ID# _____

Group#_____

Secondary Insurance Information (if applicable): _____ ID# _____

Group#_____

Informed Consent/Client Agreement

To be completed by the client and signed by client and the healthcare provider.

Read each item below and initial in the space provided if you understand each item and agree to follow your provider's instructions. A parent or guardian of a client under the age of 18 must also read and understand each item before signing the agreement. Do not sign this agreement if there is anything you do not understand about the information you have received.

I,_____(client name) understand and agree to the following:

The therapists in the Embracing Life Changes thru Counseling, LLC are licensed in the state of New Jersey to provide psychotherapy. Psychotherapy is the process where difficulties in one's life are evaluated and treated in regard to arising and/or preexisting psychological disorders. There are a variety of techniques that can be utilized to deal with the problem (s) that brought you to therapy. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation. Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings or the recollection of events in your life. Potential benefits include significant reduction in the feelings of distress, better relationships, better problem solving and coping skills and resolutions of specific problems. In most cases, therapy eventually improves one's sense of well- being and one's relationships. In very few instances, people obtain little or no benefit from therapy. It is not always possible to predict the outcome for an individual. Given this knowledge, the decisions to participate in therapy and to terminate therapy are personal ones. These decisions may be evaluated with one's therapist. Clients may also obtain independent consultation for a second opinion at any time.

Initial here if this section has been read and understood. _____

Medical Concerns

Your psychotherapist is not a medical doctor and can therefore not recognize or diagnose medical conditions. If there are significant medical conditions that may be impacting your mental health, your psychotherapist will make the appropriate referral for you to see a medical doctor specializing in the assessment and/or treatment of these conditions. Not being a medical doctor, your psychotherapist cannot prescribe psychiatric medications, but will refer you for psychiatric consultation if necessary.

Initial here if this section has been read and understood. _____

Confidentiality

In general, the law protects the confidentially of all communications between a client and a therapist, and we can release information to others about your therapy only with your written permission (in the form of a release of information). However, there are a number of exceptions: If a client is a danger to self and/or others, client requests release of information, court orders release of information, client initiates a lawsuit, client is below the age of 18, parents have rights to therapeutic information, a child is being abused or neglected, an elderly person is being abused or neglected, an

insurance company or managed care company request a diagnosis and/or relevant clinical information.

Initial here if this section has been read and understood. _____

Cancellation Policy

There is a 24 hour cancellation policy in which case, if not due to emergency circumstances, the client will be billed an out of pocket expense of $130 for each cancellation.

Initial here if this section has been read and understood. _____

Professional Records

NJ state law and the standards of the counseling profession require that we keep treatment records. You are entitled to receive a copy of these records, unless your therapist believed that seeing them would be emotionally damaging to you. In this is the case, we could provide your records to an appropriate mental health professional of your choice. Although youare entitled to receive a copy of your records if you wish to see them, your therapist may prefer to prepare an appropriate summary instead.

Initial here if this section has been read and understood. _____

Emergencies

You may telephone your therapist in an emergency. Your therapist may not always be immediately available by phone and may not be available late in the evening. If unavailable, your therapist will return your call as soon as possible usually within 24 hours. If you cannot reach your therapist, you can call 911 or proceed to the nearest emergency room if you feel that you may harm yourself or someone else.

Initial here if this section has been read and understood.---------

Obligation of Adult Psychotherapy Clients

I understand that I must be open and honest with my therapist, although in doing soit may be painful and possibly embarrassing. Therapists can only help clients to the extent that client allows. The desire to get well and function well can only come from the client. Therapy is a process and treatment time may vary by individual. I understand that doing therapy homework can often facilitate recovery and that participating in this process is crucial. I agree to inform my therapist of any plans of self-harm, suicide, homicide, or destruction of property that could endanger any other and I agree to honor agreements with my therapist in these matters.

Initial here if this section has been read and understood. _____

Psychotherapy Contract for Adult Clients

I have read the above information, have asked questions as needed, and understand issues related to risks and benefits of psychotherapy, medical concerns, confidentiality, professional records, fees, emergencies and length of psychotherapy and the obligations of psychotherapy clients.

Initial here if this section has been read and understood. _____

Based on my understanding of these issues, I agree to proceed with treatment.

Print Name: _____ Client Signature: _____ Date: _____

Therapist Signature: _____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

Name of Patient: _____ Date of Birth: _____

I hereby authorize Embracing Life Changes thru Counseling to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

Any person or entity responsible for payment for the medical services rendered to me at the Facility, including third party payors, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me at the Hospital by employees of the Facility or any person providing services at the Facility.

Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.

Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Embracing Life Changes thru Counseling and /or its therapists.

Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.

To persons authorized by the Embracing Life Changes thru Counseling in connection with the performance of supervised research in compliance with the rules and procedures of the Embracing Life Changes thru Counseling. I also understand that an authorized researcher may contact me at some future date.

I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received. This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my medical insurance benefits to be paid directly to Embracing Life Changes thru Counseling. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any

amount not paid in my insurance plan, health service plan or health maintenance organization.

Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organizations (and preferred provider organizations). Embracing Life Changes thru Counseling may not participate with your health care coverage plan and their charges may not be covered.

By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

{Signature of patient, parent or legal guardian of patient) (Date signed)

(Witness) (Date signed)

CLIENT RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you at your home address and primary phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to the office manager. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If youbelieve your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

Social Media Policy/ Client Agreement

To be completed and signed by the client, and signed by the healthcare provider. This document outlines our office policies related to use of Social Media. It will outline how Embracing Life Changes thru Counseling therapists conduct ourselves on the internet as mental health professionals and how you can expect us to respond to various interactions.

Friending

We do not accept friend requests from current or former clients on any social media site (Facebook, Twitter, LinkedIn, etc). We believe that adding clients as friends or links on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. In the effort to respect confidentiality, we do not accept posts on our Embracing Life Changes thru Counseling or personal social media sites.

Following

If therapists from Embracing Life Changes thru Counseling publish a blog post on our website, post psychology news on various forms of social media, post on Instagram, are interviewed on Podcasts or in other forms of media, we have no expectation that you as a client will want to follow our posted content. If you choose to follow us, and use an easily recognizable name, and we happen to notice that you've followed Embracing Life Changes thru Counseling, or any other posting associated with us as mental health professionals or in our personal social media sites, we may briefly discuss it and its potential impact on our working relationship. You are welcome to use your own discretion in choosing whether to follow us. Please note that we will not follow you back. We only follow other health professionals on Embracing Life Changes thru Counseling's social media sites. One reason for this is that we believe that casual viewing of clients' online content outside of the therapy hour can create confusion in regards to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with us, please bring them into our sessions where we can view and explore them together, during the therapy session.

Communications

Please do not use social networking sites to contact Embracing Life Changes thru Counseling or our therapists. These sites are not secure and we may not read the messages in a timely manner. Please do not post on walls, use hashtags or @replies, or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us in this way could compromise your confidentiality. It may also create the possibility that these exchanges could become a part of your legal medical record and documented in your chart. If you need to contact us between sessions, the best way to do so is by phone.

Business Review Sites

Business review sites such as Yelp, Healthgrades, Bing, Doctor Finder, or other places which list businesses may include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that this is not a request for a testimonial, rating, or endorsement from you as our client. It is against the American Psychological Association's code of ethics to solicit reviews. Of course, you have a right to express yourself on any site you wish. Please note, due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative.

Email

We attempt to communicate via email only to arrange or modify appointments. Please do not email content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with us via email, be aware that all emails are retained in the logs of your and our internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Please also be aware that any emails we receive from you and any responses that we send become a part of your legal record.

Social Media Policy

I have read the above information, have asked questions as needed, and understand issues related to social media interactions and expectations. I understand the limits of confidentiality when utilizing social media and/ or following Embracing Life Changes thru Counseling social media account.

Print Name:.....

Client Signature: _____

Date: _____

Therapist Signature: _____

HIPAA (Health Insurance Portability and Accountability Act)

THIS NOTICEDESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOCED AND HOW YOU CAN GET ACESS TO THISINFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice of Client Rights: You have the right to receive full information from your counselor about her professional knowledge, skills, preparation, experience, and credentials. You have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment. You have the right to have explained to you how a therapy technique works as well as given an explanation for its intended purpose before it is employed. You have the right to refuse particular therapy technique or method. You have the right to request restrictions on certain uses and disclosures of your counseling records. However, your counselor is not required to agree to a restriction you request. You have the right to request and receive confidential communications from your counselor by alternative means and at alternative locations. For example, if you don't want coworkers to know that you are seeing a therapist, you can direct your counselor to telephone you only at home. You have the right to inspect and/or obtain a copy of your or your minor child's counseling record as the record is maintained. You have the right to request an amendment of your or your minor child's counseling record for as long as the record is maintained. Your counselor may deny your request. You generally have the right to receive an accounting of disclosure from your, or your minor child's counseling record, for which you have neither provided consent not authorization, Such disclosures are described under the section: "Confidentially" in the Informed Consent/Client Agreement which was given to you. You have the right to complain should you believe your privacy rights have been violated. In such cases first discuss the concern with your counselor. If you are not satisfied with the outcome, you may file a written complaint with the New Jersey Professional Counselor Examiners Committee at 973-504-6582 or via email at: AskConsumerAffairs@lpc.state.nj.us.

Notice of Privacy Practices: Your counselor has been and will always be committed to maintaining clients' confidentially. She will only release information about your counseling records in accordance with federal and state laws and ethics of the counseling profession. This notice described your counselor's policies related to the use and disclosure of your counseling records. Uses and disclosure of your counseling records for the purposed of providing services- providing treatment services, collecting payment, and conducting counseling operations are necessary activities for quality care. State and federal laws allow your counselor to use and disclose information from your counseling records for these purposes.

Treatment: Your counselor may need to use or disclose information from your counseling records to provide, manage, or coordinate your treatment or related services, which could include consultations with medical or mental health professionals and potential referral sources.

Payment: Your counselor may need to disclose information for your counseling records that is needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes.

Counseling Operations: Your counselor may need to use information about you to review her treatment procedures and business activity. This may involve supplying a government agency with statistical data. In such cases your name and personal information will not be divulged.

Other uses or disclosure of your information that does not require your authorization or consent- these disclosures are described under the section: "Confidentially," in the Informed Consent/Client Agreement; provided to you.

I have been given a copy of this document for my personal keeping:

Client Signature (or person authorized by law) Date

Telehealth Counseling Consent:

Client Name: _____

Date of Birth: _____

Location of Client: _____

Introduction:

Telehealth is the form of teletherapy that allows clients to access mental health therapy care using audio-video interface such as videoconferencing. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health care/ therapy by enabling a client to remain in his/her home.
- More expeditious scheduling for therapeutic evaluation and management.
- Obtaining expertise of a clinician while removing barriers including, but not limited to transportation, childcare concerns, medical issues which limit mobility.

Possible Risks/Limitations:

As with any therapy visit, there are potential risks and limitations associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate diagnostic decision making by the clinician and/or consultant(s);
- Delays in therapy evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information;
- In rare cases, a lack of access to complete client history may result in judgmental errors.

Logistics:

Your clinician will call you at your scheduled time or send you a link for our secure and HIPAA compliant video session. We expect that you are available at our scheduled time and are prepared, focused and engaged in the session. Your clinician will be calling you from a private location where s/he is the only person in the room. It is expected that you also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others that can hear you, the clinician cannot be responsible for protecting your confidentiality. Every effort must be made on your part to protect your own confidentiality. We suggest you wear a headset to increase confidentiality and also increase the sound quality of the sessions. Please assure you reduce all possibilities of interruptions for the duration of

our scheduled appointment.

Please know that per best practices and ethical guidelines, we can only practice in the state that we are licensed in (New Jersey). That means wherever you reside, your clinician must be licensed. You agree to inform your clinician if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

*Please initial to indicate you have read and agree to the information on this page:*_____

Connection Loss During Video Sessions:

If connection is lost during a video session, your clinician will call you to troubleshoot the issue. If your clinician cannot reach you, s/he will remain available to you during the entire course of the scheduled session. Should you contact your clinician back and there is time left in your session we will continue.

Recording of Sessions:

Please note that recording, screenshots, etc. of any kind of any session is not permitted without written consent.

Safety:

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.

If the clinician has concerns about your safety during a telehealth counseling session, your clinician will call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during telehealth counseling sessions.

By signing this form, I understand and agree to the following:

I understand that the laws that protect privacy and the confidentiality of personal information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

I understand that I have the right to inspect all information obtained in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.

I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time.

I understand that it is my duty to inform my clinician of any other healthcare providers involved in my medical/psychiatric/mental health care.

I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent For The Use of Telehealth Counseling Services:

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my mental health care.

I hereby authorize Embracing Life Changes thru Counseling LLC to use telehealth in the course of my diagnosis and treatment.

Signature of Patient: _____ Date: _____

(person authorized to sign for patient): _____ Date: _____

If authorized signer, relationship to patient: _____

Clinician Signature & Credentials: _____ Date: _____

I have been given a copy of this consent form (patient's initials) _____

Release of Information

Date: _____

Client Name:.....Date of Birth:.....

I hereby consent for information regarding the treatment and progress of the above patient to be shared between Embracing Life Changes thru Counseling Group LLC therapists and the parties listed below. All information shared is considered confidential therefore patient permission is mandatory. This release of information form has no expiration date unless otherwise noted. You must give a written retraction of the right to share your information should you decide that you no longer wish for the associated to speak to the parties listed regarding your care. Your privacy is our number one priority.

Embracing Life Changes thru Counseling Group, LLC therapists have permission to speak to, and receive information from, the following party regarding my care:

(Please enter Emergency Contact's information below)

Name: _____ Address: _____

City/State/Zip code: _____

Phone:_____ Fax: _____

Client Signature: _____ Date:_____

Parent/Guardian Signature: _____Date:_____

Coordination of treatment authorization or declination / Primary care or other medical P roviders

I,_____(client name) allow Embracing Life Changes thru Counseling Group, LLC therapists to communicate (release or obtain information) with the following providers:

PCP/ medical provider's name and address(es):

I understand this communication will allow the therapists in the Embracing Life Changes thru Counseling, LLCand my other providers to coordinate and provide me with high quality care.

By **initialing each line,** I allow Embracing Life Changes thru Counseling, LLCto include the following information:

___ Name and identifying information.

___ My diagnosis, attendance, psychiatric and medication related information, assessments results and history.

___ My information about alcohol or drug status

___ My information about HIV or AIDS status

By **initialing one** of the following lines, I indicate that I will allow this communication to continue:

___ Until I take back by permission **OR** ___ For the time I amin therapy (up to one year)

I know that I can take back my permission for Embracing Life Changes thru Counseling to communicate with my provider at any time by letting them know in writing. I know that I can receive treatment at Embracing Life Changes thru Counseling whether I fill out this form or not. I have also read and understand the information on the bottom of this form.

Client Signature Date Staff Signature Date

I have not completed this form because: (initial one and sign below)

___ I do not have a PCP and I have been given referrals for providers in my area.

I have spoken with my Embracing Life Changes thru Counseling therapist about coordination and do NOT want her/ himto coordinate with my PCP. I know that I can change this position at any time and request coordination of treatment.

Client Signature Date Staff Signature Date

I understand that I may revoke this Authorization in writing at any time, except that the revocation willnot have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I understand that the Provider cannot guarantee that the Recipient willnot re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2). I hereby acknowledge receipt of a copy of this authorization.