Living Life Counseling Center
Patient Registration Form

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____Work Phone #: _____

Employer: _____ Social Security #: _____

Birth Date: _____Age: ____ Gender: _____ Marital Status: _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____

Home Phone #: _____ Work Phone #: _____ Living Arrangement: _____

Responsible Party Information

Responsible Party is Patient: Yes No

First Name: _____ Last Name: _____ Relationship to Patient: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone #: _____Work Phone #: _____

Financial and Policy Holder Information

Primary Insurance:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

Secondary Insurance: Yes No

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

Authorization to Release Information: The undersigned authorizes **Living Life Counseling Center** and any associate rendering service to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payer (s) including the third-party payer(s) agent and/or representative or anyone responsible for payment of services.

Assignment of Benefits: The undersigned assigns to and authorizes direct payment of benefits (including insurance benefits, otherwise payable with respect to the patient) to **Living Life Counseling Center.** The undersigned agrees to assist in processing claims for benefits.

Financial Responsibility: In consideration of the services provided or to be provided, the undersigned agrees to pay **Living Life Counseling Center** for the services rendered or to be rendered to above-said patient within 90 days. In failing to do so, I hereby waive all claims or rights to exemption and agree to pay the reasonable cost of collection, including a reasonable attorney's fee for the collection of the account if assigned to an attorney for collection.

I acknowledge that I have read this form and understand its purpose and content.

Guarantor (Agreement to Pay)	Patient (or authorized Representative/Relationship to Patient)
Date	Date

Living Life Counseling Center

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
In the State of Alabama, minors, ages 14 and older have the right to consent to receive treatment without parental approval. Children under the age of 14 must have parental consent.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Billing and Cancellation Policy

Billing

Our policy is full payment at the time service is rendered. We accept Cash, Visa, Discover and Master Card. There will be a $30.00 service charge for each returned check.

If you will be utilizing your medical insurance, please make sure to present your insurance card along with the responsible payer's driver's license at the time of your appointment.

Please be aware that benefits quoted by your insurance company are not a guarantee of payment. You will be asked to pay any charges not paid by your insurance company.

Cancellation

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that there will be a $60.00 cancellation fee if it is not cancelled within the 24 hours. Exceptions are made for cancellations due to illness or an emergency.

A $60.00 no show fee will also be charged, when you fail to show for your scheduled appointment and do not call to cancel within 24 hours of your appointment. Exceptions are once again illnesses and emergencies.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Living Life Counseling Center

Notice of Policies and Practices to Protect the Privacy of Your Health Information

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your personal health information. Please review this notice carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

LLCC may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To clarify these terms, here are some definitions:

PHI: refers to information in your health record that could identify you.
Treatment: is when the clinician provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when the clinician consults with another health care provider, such as your family physician or another psychologist. **Payment:** is when the clinician obtains reimbursement for your healthcare. Examples of payment are when the clinician discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations: are activities that relate to the performance and operation of the practice. Examples of health care operations are quality assessment and improvement activities, business- related matters such as audits and administrative services, and case management and care coordination.
Use: applies to only activities within the clinician's office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
Disclosure: applies to activities outside of the clinician's office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

The clinician may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the clinician is asked for information for purposes outside of treatment, payment or health care operations, the clinician will obtain an authorization from you before releasing this information. The clinician will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes the clinician has made about you and the clinician's conversation during a private, group, joining, or family counseling session, which the clinician has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) the clinician relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

The clinician may use or disclose PHI without your consent or authorization in the following circumstances:

Child abuse: If the clinician has reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, the clinician must immediately report the matter to the appropriate authority.

Adult and Domestic Abuse: If the clinician, in the performance of their professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse, the clinician must promptly report the matter to the appropriate authority.

Health Oversight Activities: If the Alabama Professional Licensing Body is investigating the clinician's competency, license or practice, the clinician may be required to disclose protected health information regarding you.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the counseling or psychotherapy services provided to you, and/or the records thereof such information is privileged under Alabama law, the clinician shall not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. The clinician shall inform you in advance if this is the case.

Serious Threat to Health or Safety: The clinician may disclose protected health information regarding you where there is a clear and imminent danger to you or another individual or to society, and then only to appropriate professional workers or public authorities. If you are at risk, the clinician may also contact family members or others who could assist in providing protection.

Worker's Compensation: If you have filed a worker's compensation claim, the clinician may be required to disclose PHI about any services the clinician has provided to you and that are relevant to the claimed inquiry.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:
Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, the clinician is not required to agree to a restriction of your request.

Right to Receive Confidential Communication by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI
by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing the clinician. On your request, the clinician will send your bills to another address.) We will obtain such requests that are reasonable and will not request an explanation by you.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, the clinician will discuss with you the details of the accounting process.

Living Life Counseling Center

Notice of Policies and Practices to Protect the Privacy of Your Health Information

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of your PHI in the clinician's mental health and billing records used to make decisions about you for as long as the PHI

is maintained in the record. The clinician may deny you access to PHI under certain circumstances, such as when a health care professional believes access may cause harm to the individual or another person. In such situations, the individual will be given the right to have such denials reviewed by a licensed health care professional for a second opinion. Upon your request the clinician will discuss the details of the request and denial process. Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The clinician may deny your request. On your request the clinician will discuss with you the details of the amendment process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from the clinician upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties
The clinician is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.

The clinician reserves the right to change the privacy policies and practices described in this notice. Unless the clinician notifies you of such changes, however, the clinician is required to abide by the terms currently in effect.

If the clinician revises the policies and procedures, the clinician will provide you with written notice by hand or mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision the clinician has made about access to your records, or have other concerns about your privacy rights, you may contact the clinician at the office.

If you believe that your privacy rights have been violated and wish to file a complaint with your clinician, you may send your written complaint to the clinician's office.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services of Civil Rights 200 Independence Avenue SW Room 509 HHH Building Washington DC 20201.

You have specific rights under the Privacy Rule. The clinician will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on the date signed below. The clinician reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that the clinician maintains. The clinician will provide you with a revised notice by hand or mail.

_____	_____	_____
Patient Signature	Parent Signature (if patient is a minor)	Date