THE NEXT STEP COUNSELING CENTER, LLC

REGISTRATION FORM

(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) 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:		Social Security no.:		Home phone no.: ( )		
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 ❑ Close to home/work ❑ Internet ❑ Other						
Parent Name if patient is a minor:						

INSURANCE INFORMATION

(Please be prepared to present your insurance card.)

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] ❑ Welfare *(Please provide coupon)* ❑ 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 Next Step Counseling Center, LLC. I understand that I am financially responsible for any balance. I also authorize The Next Step Counseling Center, llc or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Office Policies and Regulations

We take pride in the services we have to offer you and are dedicated to helping you in whatever way we can. Below is a list of general ***Office Policies*** that we ask that you abide by as clients. In order to better help you, please assist us in being quiet, on time, and having professional office behaviors. Please be advised that our sessions are 50 minutes. Thank you in advance for your cooperation in assisting us to keep a therapeutic atmosphere.

IN THE OFFICE

1. Please keep a reasonable noise level and only bring those necessary, due to office space being limited. There also shall be no smoking (including vapor pens) in our office facility.
2. All NEW patients must complete all intake documents and forms before being seen. Clients are also responsible for updating any/all information including Insurance Information, Address, Phone Number and Email Address on a need to basis. At the beginning of each year patients must update the documents.
3. Copayments, deductibles, and administrative fees will be collected on the date of the appointment unless under extenuating circumstances. You will not be rescheduled until you are up to date on payments.
4. If a minor is being seen in this office and the parents are separated or not married, it is your responsibility to follow the court's custody order in notifying and gaining consent from the other parent. Signing this document verifies that you are in compliance with the law.
5. We understand that at times it may be necessary for us to be subpoenaed to court as a fact witness. Our fee for court time is $75 per hour including travel time to and from the courthouse.

No-Show Appointment or Late Cancellation Policy

Please give notice if you are unable to keep your appointment. Any missed appointment or any cancellation of appointments within 24 hours of your scheduled session prevents access to other patients who would want your scheduled time. Any missed appointment or cancellation of appointments within 24 hours of scheduled time will result in a 25.00 fee. Repeated cancellations (more than two) without the required 24 hours' notice may result in termination of counseling. Multiple no-shows will result in the termination of counseling.

For appointments made within 24 hours of scheduled time no such cancellations will be accepted. Missing one of these appointments will also result in the 25.00 fee.

_____ _____

(Printed Client Name) (Date)

_____

(Signature of client/guardian)

The Next Step Counseling Center, LLC
LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

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

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature

_____
Client's Parent/Guardian if under 18