Reflections Counseling
3220 E. Jefferson Blvd South Bend IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

Registration Information

Today's date _____

Gender Identification (Check one): Male Female

Client's Last Name | First Name | Middle Initial

Parent/guardian name

Client's Social Security # | Birthdate | Age

Street Address | City | State | Zip Code

Home Phone | Cell Phone | E-mail Address

Where can we leave messages? Home ☐ Cell ☐ E-mail ☐*

Can we text you? Yes ☐* No ☐

*Please be aware the we take every precaution to maintain your confidentiality; however, we cannot guarantee confidentiality of electronic mail or other electronic services.

Employer | Occupation

Name of Primary Care Doctor | Phone # | Fax #

Insurance Information

In order for us to file bills with your insurance you must complete all of the following information. Your signature and initials are required at the end of this section. We will also need a copy of your insurance card(s).

Insurance Company Name | Insurance ID # | Group#

Policyholder's name | Policyholder's birthdate | Policyholder's social security #

Policyholder's address ☐same as above | City | State | Zip

Policyholder's employer | Client's relationship to Policyholder | Policyholder's phone #

Name of EAP (if relevant) | Authorization # | # of Sessions Authorized

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History

Do you see a psychiatrist for medication? Yes No

If yes, what is your psychiatrist's name? _____

Please list any medications you are taking: _____

How would you rate your overall health? 1 2 3 4 5
Poor Neutral Excellent

Marital Status: single married separated divorced widowed significant other

Please list some of the important people in your life:

Name Relationship to you

Emergency Contact Information

Emergency Contact Person Phone # Alternate Phone #

Relationship to Client

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What Brings You In

Below are problems that some people face. Please check those that pertain to you.

Suicidal Thoughts	Cutting/Burning Self	Obsessions
Excessive Worrying	Drug/Alcohol Use	Mood Swings
Nervousness	Work Trouble	Impulse Control
Panic Attacks	Relationship Trouble	Parenting Struggles
Shyness	Trauma	Hallucinations
Stress	Eating Problems	Physical Health Problems
Depression	Sleep Problems	Anger/Irritability
Concentration	Fears	Hyperactivity
Motivation	Finances	Physical/Sexual Abuse

What are your short-term goals for therapy?

_____

_____

_____

What are your long-term goals for therapy?

_____

_____

_____

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Financial Policy

We are committed to providing you with the best possible care in the most cost effective way possible. Please review our financial policy below.

We accept cash, checks, and credit card payments; we charge a $25.00 bank charge for returned checks. If you have insurance, we will work with you to help you receive the maximum benefit possible. If your insurance authorizes a service (or the service does not require authorization) and subsequently does not process the claim or denies the claim, you are responsible for the full balance.

Please pay all co-pays, co-insurance, and deductible amounts at the end of each session. If you cannot afford to settle your account in full at the end of a session, we do have payment plans available. We take most insurance and ask that you call the number on the back of your insurance card prior to your appointment to verify benefits and coverage.

If you have a secondary insurance and you do not provide a copy of the insurance card at the first appointment, you will be responsible for all copays resulting from your visit. Reflections Counseling is not responsible for billing your secondary insurance if you do not provide proper documentation.

For an account that becomes delinquent (overdue 90+ days) we reserve the right to charge a 35% collection-handling fee on the balance to send to a collection agency. At that point, you will be responsible for all costs associated with the collection process to the extent permitted by the law.

If you do not attend a scheduled appointment and do not call your therapist within 24-hours prior to the appointment, we reserve the right to charge a $65.00 no-show fee. If you do not attend a scheduled appointment with Dr. Knapp or Dr. Holleman, you will be responsible for the full cost of the appointment.

By signing below, you are agreeing to our financial policy. The enforcement of this agreement is governed by the State of Indiana. We reserve the right to change this policy at any time.

Any credit card charges over $100.00 are subject to a 3% processing fee.

Please ask any questions you may have about this document prior to signing.

_____

Printed Name of Client

_____

Signature of Client or Parent/Legal Guardian Date

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HIPAA Acknowledgment

I understand that I have specific rights to privacy regarding my protected health information. (Protected health information refers to information that is related to past, present, and future information about your physical and mental health.)

I understand that this information can be used to

- Obtain payment from insurance companies and other third-party payers, including secure electronic billing.
- Conduct, plan, and direct my treatment among healthcare providers who may be involved directly or indirectly in my treatment.
- Perform normal operations such as quality of care assessments and provider certifications.

I understand that it is the clinician's obligation to contact Child Protective Services (CPS) if an individual discloses abuse, neglect, or risk to a child or vulnerable adult.

I received a copy (electronic or paper) of the privacy policy and was given the opportunity to review this policy before signing this acknowledgment.

I understand that Reflections Counseling has the right to make changes the privacy practices. I have the right to contact Reflections Counseling at any time to obtain the most current copy of the privacy policy.

I understand that I may request certain restrictions related to how my protected health information is used or disclosed for treatment or payment. This request must be made to Reflections Counseling in writing. I further understand that Reflections Counseling is not required to comply with my request.

Please ask any questions you may have about this document prior to signing.

_____ (initial) I understand the certain information about me can be released to insurance companies in order to process claims.

_____ (initial) I authorize payment of medical benefits to the provider for mental health services delivered

_____ (initial) I understand that co-pays are due at the time of service

_____ (initial) I understand that I am financially responsible for services rendered that are not covered by the above-mentioned insurance company

I hereby give permission to Reflections Counseling to provide me with mental health services within the scope of the provider's license and training. My signature indicates that I have read and agree to abide by the above financial policy in exchange for mental health services.

_____

Printed Name of Client

_____

Signature of Client or Parent/Legal Guardian Date

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This document is to explain the fees associated with letters and court appearances. For those clients involved in the legal system (court ordered counseling or custody situations), it is your responsibility to inform Reflections Counseling and your assigned clinician. All clients of Reflections Counseling are required to review and sign this form prior to the first session.

Reflections counseling or any of the clinicians are not court appointed evaluators for child custody and cannot determine the living arrangements of your child(ren). Involving the legal system in counseling interferes with the treatment process and can pose significant psychological risks. Clients are **strongly** discouraged from having Reflections Counseling or any of its clinicians release confidential information regarding treatment or to testify on their behalf.

If a client requires their clinician to be involved in legal matters, he or she will be responsible for the additional fees outlined in this document. **None of the following fees are covered by insurance and are the sole responsibility of the client.** Keep in mind that Reflections Counseling and its clinician's testimony may not be solely in your favor or best interest. **We can only testify as a factual witness.**

Fee Schedule:

- Letters to a 3rd party (court, school, disability, etc): $30
- Preparation time (including submission of records): $220/hr
- Phone calls: $220/hour
- Depositions: $250/hour including travel time
- Time required in giving testimony: $250/hour (from the time leaving office to the time we return to the office)
- Time away from office due to depositions or testimony: $220/hour
- Filing a document with the court: $100
- $1500 minimum **non-refundable** retainer for subpoena court appearance.

A retainer of $1500 is due in advance prior to the court hearing. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "express" charge. If the case is continued with less than 72 business hours' notice, then the client will be charged $500 (in addition to the retainer). Should the case be continued, and we are served another subpoena, the above will be required for each subpoena received for each court date. Should we receive a subpoena from multiple attorneys for the same case. The above is required for each individual party and each subpoena served. Once hearings are completed any additional charges not covered by the retainer will be billed separately. If the retainer is not paid prior to the court hearing, a copy of this signed agreement will be taken into the court hearing and the therapist will ask to address the judge prior to testimony and petition for mandatory payment prior to testimony and have payment become court ordered. Please note, should it become court ordered and you do not pay the required fees, this means the court can hold you in contempt.

_____ _____
Name of Responsible Party (Printed) Date

_____ _____
Signature of Responsible Party Date