Patient Registration/Financial Agreement

Name:_____
(First) (Middle Initial) (Last)
Address:_____ City:_____ State_____ Zip_____

Phone:_____(cell)_____ Date of Birth:_____

Email:_____ Social Security:_____

I would like a reminder call or email at least 24 hrs prior to each upcoming appointment? Y or N
This can be done by (circle) email or phone.

Employer of Client or Guardian:_____ Employer Phone:_____

Emergency Contact:_____ Phone:_____

Financial/Insurance Information: Please allow us to make copies of all of your insurance cards as well as your driver's license. The following information is necessary to process insurance claims:

Primary Insurance:_____ Policy Holder's Name_____

Policy Holder's Address (if different):_____ Phone:_____

Date of Birth of Policy Holder: _____ Social Security Number:_____

Secondary Insurance:_____ Policy Holder's Name:_____

Date of Birth:_____ Social Security Number:_____

I authorize the release of any medical information necessary to process my claims. I hereby authorize C&W House to apply for benefits on my behalf for services rendered by them. I request that payment from my insurance company be made directly to C&W House.

I am responsible for all copays/coinsurances, which are due and payable at the time services are rendered, as well as deductible amounts. If, for some reason, insurance denies my claims, I am responsible for these balances as well. If further action ever becomes necessary and is taken in order to collect any delinquent balance due on my account, I agree to pay for all collection, attorney, and court fees incurred by C&W House for the collection of any and all balances due on my account. I am aware that 1.5% interest is assessed on all account balances each month. By signing below, I acknowledge: I have read and understand the preceding statements regarding my insurance, as well as my financial responsibilities, including if insurance does not pay.

Signature:_____ Date:_____

Witness:_____ Date: _____

Counseling and Wellness House Medication Reconciliation Form (Med Log)

Name:		Date:	
Date of Birth:			
Allergies & Reactions:			
Pharmacy:		Phone:	FAX:
Other Medical Problems:			

Medications (Include OTC and Herbals)

Name, Dosage, and Instructions	Prescriber	Reason for Rx	Start Date	Stop Date	Comment /Codes *

The Counseling and Wellness House LLC
Tara Eytcheson, LCSW
1535 E 100 N
Kokomo, IN 46901
Phone: 765-450-5657 Fax: 765-450-6851

COORDINATION OF CARE FORM

Client's Name:_____ DOB:_____

Name of Primary Care Physician of Client:_____

Dear:

This letter is to only inform you that the above-named member was seen for initial behavioral health evaluation on _____

for _____
(reason/diagnosis)

Brief Summary (if indicated):

_____
_____
_____
_____

Current Treatment:

- Psychotherapy
- Psychological Testing
- Other:_____

Sign if you consent to a letter of coordination to be sent to your Physician:

_____ _____
Client Signature / Date Signature of Provider / Date

_____
Signature of legal guardian / Date

I Decline to have a letter sent to my Primary Care Physician:_____

The Counseling and Wellness House LLC
1539 E 100 N
Kokomo IN 46901
Phone: 765-450-5607 Fax: 765-450-6351

CONSENT TO TREAT

_____ We/I agree to allow The Counseling and Wellness House (C&W House) to provide services to myself/our family. We/I understand that we/I may choose another provider for this service, and we/I have freely chosen to work with C &W House.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS

_____ I authorize my provider to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my provider on my behalf.

We/I understand the purpose for and have completed the following or received the following information:

_____ Financial Contract/Payment Agreement
_____ Release of Information
_____ HIPPA
_____ Consent to Treat
_____ Client Rights

_____ _____
Client/Guardian's Signature Date

_____ _____
Staff Signature Date

The Counseling and Wellness House LLC
1539 E 100 N
Kokomo, In 46901
Phone: 765-450-5657 Fax: 765-450-6353

PRIVACY NOTICE (HIPPA) ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information maintained here at The Counseling and Wellness House, LLC (C&W House). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved in that treatment directly, or indirectly.

2. Obtain payment from third party payers.

3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have been informed by C&W House of my right to privacy and obtained a copy of the Privacy Notice, which contains a more complete description of the possible uses and disclosure of my health information. I was given the right to review the Privacy Notice prior to signing this consent form. I understand that C&W House has the right to change its' Privacy Notice at any time and that I may contact the organization at any time in order to obtain a current copy of the Privacy Notice.

I also understand that if I need more information or have questions, I may contact C&W House at the number listed on the Privacy Notice. I understand that I may request in writing that C&W House restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that C&W House is not required to agree to my requested restrictions, but if C&W House agrees to my restrictions, then the organization is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that C&W House has taken action relying on this consent.

_____ _____

Client/Guardian's Signature Date

_____ _____

Staff Signature Date

The Counseling and Wellness House L...
1539 E 100 S
Kokomo IN 4[illegible]
Phone: 765-[illegible]857 Fax: 7[illegible]

CLIENT RIGHTS

1. I have the right to decide not to enter therapy with the Counseling and Wellness Center, LLC (C&W House). If I wish, names of other therapists will be provided.

2. I have the right to end therapy at any time. The only thing I will have to do is to pay for any treatments I have already had. I may, of course, have problems with other people or agencies if I end therapy— for example, if I were sent for therapy by the courts.

3. I have the right to ask any questions, at any time, about what we do during therapy, and to receive answers that satisfy me. If I wish, each method will be explained to me.

4. I have the right not to allow the use of any therapy technique. Upon my request the benefits and risk of each technique will be shared.

5. I have the right to keep what I tell C&W House staff private. Generally, no one will learn of our work without my written permission. There are some situations to which C&W House is required by law to reveal some of the things I report, even without my permission, and if C&W House does reveal these things C& W House is not required by law to tell me that it was done so. Here are some of these situations:
   A. If I seriously threaten to harm another person, C&W House must warn that person and the authorities.
   B. If a court orders C&W House to testify about me, C&W House must do so.
   C. If C&W House is testing or treating me under a court order, C&W House must report findings to the court.

D. If C&W House wishes to record a session, C&W House will get your informed consent in writing. I have the right to prevent any such recording.

E. I have the right to review my records in my file at any time, upon written request. If I disagree with anything documented in my records, I have the right to amend (not delete) my records.

F. **Minors and Parents:** Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, your therapist will provide them with only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Your therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless your therapist feels that the child is in danger or is a danger to someone else. In which case, your therapist will notify parents of his/her concerns. Before giving parents any information, your therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections he/she may have.