Stepping Stones Family Counseling, PC

New Patient Registration

Patient Name: _____ Patient Date of Birth: _____

Responsible Person: _____ Primary Contact Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Contact Number: _____ Email Address: _____

Employer Name and Location: _____

How did you find me? _____

Patient Medical History

Primary Physician and Location: _____

Please describe any ongoing health problems: _____

_____

Please list all current medications: _____

_____

Please describe any serious illnesses or prior hospitalizations: _____

_____

Patient Psychological History

Prior Treatment Date	Counselor Name	Primary Concern

Please answer each question

Have you ever had a psychological assessment or testing? ◯ YES ◯ NO

Has your school provided an IEP? ◯ YES ◯ NO

Have you ever been hospitalized for psychiatric treatment? ◯ YES ◯ NO

Hospitalization date: _____ Length of stay: _____ Facility Name: _____

Please describe your current concerns/reasons for seeking treatment: _____

_____

Are your current concerns: MILD ◯ MODERATE ◯ MODERATELY SEVERE ◯ SEVERE ◯ CRISIS ◯

Stepping Stones Family Counseling, PC

Office Policies

The following list provides a summary of important office policies. Please indicate your understanding and acceptance of these policies by checking each box below and then signing in the place provided at the bottom of this form.

I agree that I am responsible for paying the fees that I agree upon with my therapist, regardless of whether or not I involve my health insurance company or any other third-party payor in my therapy relationship. If I ask Stepping Stones Family Counseling, PC to bill an insurance company, spouse, relative, or other person, and Stepping Stones Family Counseling, PC does not receive payment in a timely manner, I agree to promptly pay Stepping Stones Family Counseling, PC. I have provided a credit card or similar form of payment to my therapist for this purpose. I understand that I may be charged with little or no notice in the event that my fees are not paid on my behalf, regardless of the reason

Read and Accepted ☐

I understand that if I am more than 15 minutes late to an appointment, I may need to reschedule, because my therapist often has back to back appointments. I understand that I will be charged a regular session fee if I choose to keep an appointment when I am late.

Read and Accepted ☐

If you need to cancel a scheduled appointment, you are required to provide your therapist with at least 24 hours notice. If you do not keep your appointment, and do not give your therapist 24 hours notice, the credit card that you have provided to your therapist will be charged $125 for the missed appointment. Your health insurance will not cover this charge.

Read and Accepted ☐

I understand that if I miss more than two sessions without notifying my therapist, or if I have a pattern of missed sessions, or if I have not contacted my therapist for more than 14 days, my therapist may close my case and cease further treatment.

Read and Accepted ☐

I understand that no one at Stepping Stones Family Counseling, PC, including my therapist, provides or will provide, opinions of any kind, including opinions regarding child visitation or custody. There are no exceptions to this policy.

Read and Accepted ☐

I understand that no one at Stepping Stones Family Counseling, PC, including my therapist, provides testimony or expert evaluations of any kind. I understand that if my therapist is subpoenaed regarding my therapy, or my child's therapy, I agree to pay my therapist no less than $1,000 per appearance plus an additional fat fee of $4,000 per subpoena. This fee will be charged regardless of who subpoenas my therapist.

Read and Accepted ☐

I understand that email and text correspondence to my therapist is at my discretion and that the confidentiality of unencrypted information cannot be guaranteed. I understand that an email or text should not be used to communicate urgent or emergency needs.

Read and Accepted ☐

I understand that session times are typically 50 minutes in length. Longer sessions can be scheduled if available, and my therapist will make an effort to accommodate my scheduling needs. Please understand that fees for long sessions, or back to back sessions, will probably not be covered by health insurance.

Read and Accepted ☐

Client / Guardian / Primary Insured: _____ Date: _____

Stepping Stones Family Counseling, PC

Billing and Payment Consent

My therapist has provided me with a detailed Information for Clients booklet and an Office Policy form that outlines all of the features associated my therapist's services, including her fees. By signing this form, I acknowledge receipt of this booklet and I agree to pay my therapist for our therapy sessions. I acknowledge that, regardless of whether or not I elect to involve my health insurance company or any other third party in my treatment, the responsibility for paying my therapist is mine alone.

Billing Terms

My therapist will bill me for the time that I spend with her at an agreed rate. I understand that payment for my therapy is due at the end of each session, unless other arrangements have been agreed with my therapist and outlined below.

Additional Billing Terms

_____

_____

Payment method

HEALTH INSURANCE. My health insurance may cover a portion of my treatment costs and by listing my health insurance information here, I am requesting that my therapist involve my insurance provider in billing and payment for my treatment.

Insurance Provider: _____ Insurance ID Number: _____

Name of Primary Insured: _____ Group Number/Plan Type: _____

HEALTH INSURANCE CARD. I have attached a copy of my health insurance card to this form.

HEALTH INSURANCE CO-PAYMENT or CO-INSURANCE. My health insurance co-payment is _____

CREDIT CARD or E-CHECK. My therapist requires me to have an electronic payment method on file even if I elect to cover a portion of my treatment cost through health insurance.

PAYMENT METHOD: ☐ VISA ☐ MasterCard ☐ DISCOVER

Card/Account Number: _____ Exp. Date: _____

Security Code (3 Digits): _____ Billing Zip Code: _____

I agree that I am responsible for paying the fees that I agree upon with my therapist, regardless of whether or not I choose to involve my health insurance company or any other third party in my therapy relationship. If I ask Stepping Stones Family Counseling, PC to bill an insurance company, spouse, relative, or other person, and Stepping Stones Family Counseling, PC does not receive payment in a timely manner, I agree to promptly pay Stepping Stones Family Counseling, PC. I have provided a credit card or similar form of payment to my therapist for this purpose. I understand that I may be charged with little or no notice in the event that my fees are not paid on my behalf, regardless of the reason. **IN THE EVENT THAT MY THERAPIST IS NOT PAID AS EXPECTED AND AGREED, EITHER BY ME, MY INSURANCE COMPANY, OR ANY THIRD PARTY, I AUTHORIZE MY THERAPIST TO COLLECT PAYMENT USING THE PAYMENT METHOD THAT I HAVE PROVIDED ON THIS FORM.**

BY SIGNING BELOW, I AUTHORIZE STEPPING STONES FAMILY COUNSELING, PC TO CHARGE MY CREDIT CARD OR CHECKING ACCOUNT FOR CLINICAL PSYCHOLOGY SERVICES. EACH THERAPY SESSION MUST BE PAID IN FULL AT THE TIME SERVICES ARE RENDERED UNLESS OTHERWISE AGREED IN WRITING ON THIS FORM. I UNDERSTAND THAT THE OBLIGATION TO PAY MY THERAPIST RESIDES WITH ME ONLY. NO CHARGEBACK'S ARE ALLOWED FOR ANY REASON WHATSOEVER. ALL CHARGES ARE FINAL. I ACKNOWLEDGE UPON SIGNING THIS AGREEMENT THAT I HAVE CAREFULLY READ THIS CONSENT FORM, THE INFORMATION FOR CLIENTS BOOKLET, AND THE OFFICE POLICY FORM PROVIDED TO ME BY MY THERAPIST AND THAT I HAVE NOT RELIED ON ANY STATEMENTS, PROMISES OR REPRESENTATIONS OTHER THAN THOSE CONTAINED HEREIN

Client / Cardholder / Primary Insured: _____ Date: _____

Stepping Stones Family Counseling, PC

Consent to Treatment

I acknowledge that I have received and have read (or have had read to me) the "Information for Clients" booklet provided to me by my therapist in connection with the treatment that I am considering. I have had all of my questions concerning my proposed treatment and the "Information for Clients" booklet answered fully.

I hereby consent to take part in treatment with the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

Neither this therapist nor anyone else has made any promises to me concerning the potential results from engaging in treatment.

I am aware that I may stop my treatment with this therapist at any time. If I do elect to end treatment, I will still be responsible for paying for any services that I may have already received. I understand that I may have to deal with other problems if I stop treatment. For example, if my treatment was court-ordered, I will have to answer to the court if I elect to stop treatment.

I know that I must call to cancel an appointment at least 24 hours (1 day) before my scheduled appointment time. If I do not cancel my appointment and I do not arrive for treatment, I understand that I will be charged for the missed appointment. I also understand that most insurance companies do not cover the cost of missed appointments and that I will consequently be responsible for covering missed appointment costs myself. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

If my therapist is called to provide testimony in a deposition or a trial that involves me, I understand that the party requesting my therapist's presence may not reimburse my therapist for her costs or her time. I agree that if my therapist is called to provide testimony in any case that I am directly or indirectly involved in, I will pay my therapist for her time and costs at the rates set forth in the "Information for Clients" booklet.

I am aware that a representative of my health insurance company or another third-party provider may be given information about the type(s), cost(s), date(s), and scope of any services or treatments I receive.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Client Signature Date

_____ _____

Client's Guardian or Legal Representative Relationship to Client

I have discussed this document with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and their responses to our discussion concerning potential treatment give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

Stepping Stones Family Counseling, PC

Consent to Use and Disclose Your Health Information

This form is an agreement between you and Stepping Stones Family Counseling, PC Therapy. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person identified in this document.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others in order to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide you with other treatments.

By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read about our privacy and confidentiality practices as set forth in our "Information for Clients" booklet. This booklet explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you.

In the future, we may change how we use and share your information, and so we may change our confidentiality policy. If we do change it, you may get a copy from our website, www.steppingstonesfamilycounseling.com, or by calling us at (714) 363-8150 to receive an updated "Information for Clients" booklet.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations.

After you have signed this consent, you have the right to revoke it by writing to us. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Client Signature Date

_____ _____

Client's Guardian or Legal Representative Relationship to Client

Stepping Stones Family Counseling, PC

Authorization to Release and Receive Confidential Information

I understand that the purpose of this release is to assist with my treatment by authorizing communication between doctors, professional service providers or agencies, and the important individual(s) in my life, including my therapist. To further this goal, I authorize my therapist at Stepping Stones Family Counseling, PC to release information regarding me to the individual(s) listed below and to receive information from them. I have been informed of the risks to privacy and the limitations on confidentiality that this authorization and release may impose on my confidential medical information, and I accept these risks and limitations.

Unless otherwise indicated below, I authorize my therapist to release any and all information concerning my treatment and to be provided with any and all information relevant to my treatment.

_____ _____

Client Name (Printed) Client Date of Birth

Other Instructions Concerning the Release of Confidential Information:

_____

_____

_____

This information is to be disclosed to/received from these persons, who have the indicated relationship to me:

_____ _____

Name of Person Relationship to Client

_____ _____

Name of Person Relationship to Client

_____ _____

Name of Person Relationship to Client

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon, in which case such a revocation will only apply to the future release of information. This release will expire when treatment with my therapist ends.

_____ _____

Client Signature Date

_____ _____

Client's Guardian or Legal Representative Relationship to Client