

Congruent Counseling Services, LLC
REGISTRATION FORM

➤ **CLIENT INFORMATION**

Name: First _____ M.I. _____ Last: _____ Sex: M F
Date of Birth (MM/DD/YYYY): _____ Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Phones*: Home: (_____) _____ Mobile: (_____) _____ Business: (_____) _____
Indicate preferred number
Social Security Number: _____ Other Contacts: (_____) _____
Status: Single Married Other: _____ Employed: Y N Student: FT PT
Occupation: _____ Employer: _____ Phone: (_____) _____
How did you choose our office? Physician Insurance Website Word of Mouth Family or Friend
Details: _____

➤ **PARENT/GUARDIAN INFORMATION (other than subscriber info below)**

Name: First _____ M.I. _____ Last: _____ Sex: M F
Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____
Address, if different: _____ City, ST Zip: _____
Phones: Home: (_____) _____ Mobile: (_____) _____ Business: (_____) _____
Email: _____ Other Contacts: (_____) _____

➤ **INSURANCE and POLICY HOLDER/SUBSCRIBER INFORMATION**

Relationship to client (*please circle one*): Self Spouse Parent/Guardian Other: _____
Subscriber Name: First _____ M.I. _____ Last: _____ Sex: M F
Date of Birth: _____ Email: _____ Social Security No.: _____
Subscriber Address: _____ City, ST Zip: _____
Phones: Home: (_____) _____ Mobile: (_____) _____ Business: (_____) _____
Using (Please circle one): Primary Insurance EAP Benefits
Policy/Subscriber ID: _____ Insurance Co.: _____ Group: _____
Occupation: _____ Employer: _____ Phone: (_____) _____

*Congruent Counseling Services does not bill secondary insurances.
We will provide a statement at your request so that you may bill a secondary insurance.*

➤ **IN CASE OF EMERGENCY**

Name of local friend or relative (not at same address): _____ Relationship: _____
Phones: Home: (_____) _____ Mobile: (_____) _____ Business: (_____) _____

➤ **FINANCIAL POLICY and AUTHORIZING SIGNATURE**

Note that payment of your bill is considered part of your treatment, and payment is due at the time service is provided. As a courtesy to you we will help you process your insurance claims. Your insurance company and your plan benefits ultimately determine the amount paid by them. All charges you incur are your responsibility regardless of your insurance coverage; our relationship is with you, not with your insurance company. We ask that you any deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide service to you. If your insurance has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Consent: *The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Congruent Counseling Services and the provider. I understand that I am financially responsible for any balance or unpaid claim. I also authorize Congruent Counseling Services or insurance company to release any information required to process my claims.*

CLIENT/GUARDIAN SIGNATURE

PRINTED NAME (if not client)

DATE

Congruent Counseling Services, LLC Fee Schedule and Policies

Psychiatric Interview	\$275	Missed Appt/Brief Phone Session	\$50
Medication Management	\$110	Crisis Session	\$45
Psychotherapy Interview	\$150	Unscheduled Refill Request	\$35
Individual or Family Therapy	\$110	Urine Screen – THC or Panel	\$35
Intensive Outpatient Program	\$180	Letter/Form	\$25
Family Group/Parent Education	\$40	Written Report (per hour)	\$50
Medication Authorization	\$20	Disability/Workers Comp Report	\$300
Psychiatric Report (per hour)	\$100	Bounced Check Fee	\$25

Appointments

If you need to cancel an appointment for any reason, please do so 24 hours before the appointment time. ***It is office policy to charge full fee for missed appointments not canceled 24 hours prior.*** This includes groups – unless prior arrangements are made, you will be expected at the next scheduled group meeting. Insurance does not cover missed appointment charges; they are the responsibility of the client or guardian. Our office does provide courtesy reminders of your scheduled appointment. In the event these reminders are not made, it does not excuse a missed appointment.

Fees and Payment

Payment will be collected at the time service is rendered. In the case that a client has a third party insurance payer, either the client or Congruent Counseling Services, LLC will file with the insurance. Please make arrangements on or before your initial visit. If for any reason your insurance company does not cover services, the client or guardian will be responsible for all charges. You will be notified of any insurance difficulties. Statements are provided upon request.

Failure to Pay

The client agrees that failure to pay within ten business days of the service date may, at the option of Congruent Counseling Services, be construed as a discharge of services by the client. The client further agrees that in the event that legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action. ***Clients sent to collections will be charged the amount owed plus 40% for collection fees.*** The client agrees that information pertinent to the collection of any amount due be released to a third party collection agency or attorney. The client further agrees and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

Court Appearances

Congruent Counseling Services charges \$200 per hour, with a minimum of \$1,600 per day, for any court appearance whether requested or summonsed. Clients will be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. In the case of minors, the signing parent or guardian is responsible for this fee unless otherwise arranged with the non-signing parent. A deposit of \$1,600 is due 10 days prior to any court appearance. If a court appearance is canceled or rescheduled, staff must be given ten business days notice. If ten business days notice is not given, then Congruent Counseling Services may still charge up to \$1,600 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

Understanding of Separate Practices

The client recognizes and understands that although they share space, Congruent Counseling Services, LLC and Integrative Counseling, LLC are separate practices, and as such will require the opening of a new/separate client chart. The client understands that any insurance benefits utilized with Congruent Counseling Services cannot be utilized with Integrative Counseling. Integrative Counseling accepts no third party payers of any kind and has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment.

Your signature below indicates understanding of the fees and policies as delineated above.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

Congruent Counseling Services, LLC

Phone and Teletherapy Policies

Telephone and Internet Session – Teletherapy or Telepsychiatry

Modern life can make it difficult to connect with a therapist or doctor on a regular basis. Traveling, kids, busy work schedules, or going off to college can make it difficult to make the changes you need to make. In order to meet the needs of busy people, we can regularly schedule phone or Internet (Skype) counseling. This way you can work on your goals from anyplace. Teletherapy and telepsychiatry are not covered by insurance and are therefore billed at our standard rates. Clients regularly seen in the office for sessions under insurance can schedule teletherapy/telepsychiatry appointments to bridge some gap with the understanding these sessions will not be billed to insurance. Teletherapy and telepsychiatry clients will be billed via credit card at the time of service. Credit cards must be kept on file with Congruent Counseling Services. Clients may choose to receive 10% discount by prepaying for a block of ten sessions. Initial sessions must be done in person and are not billable to insurance if telephone or teletherapy/telepsychiatry sessions are the primary mode of treatment.

Missed Appointment Sessions

As noted on the Fee Schedule and Policy page, missed appointments are charged for sessions not canceled 24 hours in advance. We must charge for these missed appointments because we have reserved the time for you and cannot fill your appointment with another client if we have less than 24 hours to do so. This can be very expensive as insurance does not cover missed appointments. However, we understand sometimes life gets in the way. In order to help stay on track in counseling, and to save the full missed appointment fee, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of \$50, far less than the full missed appointment charge. This session will allow you to stay focused on your treatment and schedule your next session at a better time. The missed appointment phone option may only be used once in a 30-day period. Second missed appointments will be charged at the full rate.

Therapist and Counselor Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our counselors and therapists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office. Your counselor or therapist has provided you with personal contact information to help you address your needs. If you would like to talk with your therapist, and cannot wait until the next appointment, please be respectful of their time. In cases where you need the help, we want to help. Please note calls, texts, or emails over five minutes will be charged as crisis session at a rate of \$45. Crisis sessions are not billable to insurance and are the responsibility of the client or parent.

Psychiatrist Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our psychiatrists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office. If you are calling with a therapy or mental health concern, please call your individual therapist. Your psychiatrist has provided you with personal contact information to help you address your needs. If you would like to talk with your psychiatrist regarding medication issues, and cannot wait to schedule an appointment, please be respectful of their time. Calls, texts, or emails to clarify or change medication(s) within seven days of your last appointment are acceptable. Medication calls, texts, or emails outside this seven day window will be charged as a Crisis Session at a rate of \$45. Crisis Sessions are not billable to insurance and are the responsibility of the client or parent.

Medication Changes or Refills Between Appointments

We understand it can be difficult to keep track of medications and you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at \$35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. If you know you are unable to make an appointment for an extended period of time you may choose to schedule a Telepsychiatry appointment as described above.

Telephone, Internet, and email communication carry an inherent risk to privacy. By signing below, I indicate recognition of these risks. I have reviewed and understand these options and I have received a copy of the Phone and Teletherapy Policies.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

Congruent Counseling Services, LLC
Notice of Privacy Practices (HIPAA),
Client Bill of Rights and Confidentiality of Client Records

Client Bill of Rights

Each Client has the right to:

1. Be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.

Confidentiality of Patient Records

The Federal Law and Regulations protect the confidentiality of patient records maintained by this program. Generally the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1. The patient consents in writing;
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

Acknowledgment and Consent Regarding Notice of Privacy Practices

Our Notice of Privacy Practices is posted on the wall and is available upon request. The Notice of Privacy Practices of Congruent Counseling Services (CCS) provides information about how CCS may use and disclose my protected health information (PHI). The Notice of Privacy Practices states that CCS reserves the right to change its terms. Should this happen, understand that CCS will make the changed notice available in its office. You have the right to revoke this consent, in writing, except where CCS has already made disclosures in reliance on your prior consent. Understand that you have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment and health care operations. CCS is not required to agree to your restrictions, but if it does, it is bound by its agreement with you. By signing below, you consent to the use and disclosure of your PHI for treatment, payment and health care operations as described in the Notice of Privacy Practices. You specifically consent to CCS communicating with you using the contact information you provide, as further described in the Notice of Privacy Practices.

Discharge

Clients who choose to terminate services will be discharged immediately. Clients who have not attended sessions for 30 days or more and who do not have an appointment scheduled will be discharged at the discretion of the doctor or therapist with no prior notice. Discharged clients are no longer under the care of Congruent Counseling Services, Integrative Counseling, a therapist, or a doctor. Discharged clients may be re-admitted at the discretion of the practice upon request.

I have reviewed and understand these rights and I have received a copy.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

**Congruent Counseling Services, LLC
Primary Care Physician (PCP) Notification**

It is often helpful to notify your doctor of mental health or substance abuse treatment so that your doctor can let us know of any possible medical issues that may affect treatment. In some cases medications or medical issues can cause or worsen mental health or substance use issues. Most insurance companies also request that therapists and psychiatrists notify primary care physicians about mental health or substance abuse treatment.

Please check the appropriate box below. Checking the "Yes" box and signing this form will allow Congruent Counseling Services, LLC to notify your primary care physician.

- No, I would not like Congruent Counseling Services to notify my PCP.
- Yes, I would like Congruent Counseling Services to notify my PCP.
If you check yes, please fill out the rest of this form to the best of your ability.

I give permission to Congruent Counseling Services to notify my Primary Care Physician that _____ is being seen by _____. I understand that a copy of this letter may be placed in my chart and I encourage my doctor to discuss my treatment with me.

Dr. _____
Address: _____

Phone Number: _____ Fax Number: _____

Client Signature	Date
Parent/Guardian Signature	Date
Witness Signature	Date

This area for office to complete:
_____ is seeing your patient for

If you have any questions, comments, or concerns please contact us by phone at 410.740.8066. You may also reach us by email at congruentcs@gmail.com.

Sincerely,

Congruent Counseling Services

Confidentiality Notice

PLEASE NOTE: This document contains information belonging to the sender which is legally privileged and confidential. The information is intended for the use of the individual or entity to whom it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you received this telecopy/facsimile in error, please immediately notify us by telephone at 410-740-8066 to arrange for the return of these documents.

Congruent Counseling Services, LLC
Release of Information

I, _____ hereby authorize Congruent Counseling Services, LLC
to exchange information with: _____
Name of Program, Agency, or Individual

_____ Phone

_____ Fax

The following information may be exchanged:

- _____ Full client record
- _____ Progress and attendance reports
- _____ Admission and discharge diagnosis and recommendations
- _____ Reason for termination of treatment and discharge summary
- _____ Urinalysis/Breathalyzer results
- _____ Immunization and physical records
- _____ Other _____

The above information will be exchanged for the following reason(s):

- _____ To coordinate treatment
- _____ As a condition of probation, parole, or adjudication
- _____ As required by my employer or EAP
- _____ To assist my attorney
- _____ Other _____

This consent will expire one year from the date of signature unless otherwise noted
_____.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

Client Signature Date

Parent/Guardian Signature Date Witness Signature Date

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Client Bill of Rights and Confidentiality of Client Records

Client Copy

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Each Client has the right to:

1. Be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
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Congruent Counseling Services, LLC

Fee Schedule and Policies

Client Copy

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