## Patient Registration Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: M / F

Parent/ Caretaker Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work/ other telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

**Primary**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Doctor/Pediatrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Medicaid – Circle Plan: STANDARD FIRST CHOICE BCBS ABS TOTAL CARE

MOLINA WELLCARE ADVICARE

**IF YOU HAVE MEDICAID AND CHANGE PLANS PLEASE NOTIFY US IMMEDIATELY. A CHANGE IN PLAN MAY AFFECT CONTINUED TREATMENT AND/OR STOP TREATMENT. YOU WILL BE RESPONSIBLE FOR ALL PAYMENTS OF ANY SESSIONS IF YOU CHANGE PLANS AND DO NOT NOTIFY US.**

### Secondary

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/ Phone for providers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONCERNS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(For therapists use)DIAGNOSIS:

Primary DX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional DX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Family Bridges Therapeutic Associates LLC

# 635 South Hazard

# Georgetown, South Carolina 29440

Phone: 843-240-1782, 843-240-1783 Fax: 1- 888-282-6745

 **Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## Consent to Treatment/ Release for Insurance/ Third Party Payer

I acknowledge that I have received, have read, or have had read to me, and understand information provided to me about the therapy I am considering and have asked and had answered any questions regarding the treatment considered. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward developing and meeting the treatment goals that are in my best interest. I agree to play an active role in this process. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

I understand that no promises have been made as to the results of the treatment or any of the procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only services that I will be responsible for paying are the services I have already received. I understand that I may lose other services or may have to deal with other consequences if I stop treatment. Therapy sessions are weekly or every other week and vary in length from 25 – 60 minutes depending on age and treatment goals.

I know that I must cancel a scheduled appointment at least 24 hours before the time of the appointment. If I do not cancel or come to a scheduled appointment, I will be charged for that appointment. I can be reached by phone and when in session do not answer but check messages frequently. In case of emergency dial 911.

I am aware that a third party payer/ insurance company may be given information about the types, costs, dates and providers of any services or treatment I receive. Including primary care doctor.

This form authorizes Family Bridges Therapeutic Associates LLC to release information from my/ the patient’s records maintained while I was treated by this provider. This information may include but is not limited to intake summaries, clinical records, summaries, treatment plans, and other clinical documents such as psychological evaluations, testing records, behavioral observations, checklists, recovery plans, aftercare plans, social histories, assessments, diagnoses, prognoses, recommendations, and discharge summaries.HIV-related information and drug and alcohol information contained in these records will be released in these records will be released under this consent unless indicated here.

\_\_\_\_\_\_ Do not release.

This information may be sent to a third party payer or its agents and is needed for the following purposes:

* Receiving health insurance benefits, reimbursements, payments for services, and other similar purposes.
* Applying for life, disability, or other insurance

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Federal regulations (42 C.F.R. Part 2, Sections 2.31(a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating, and acting upon it according to their specific and advanced professional training in the mental health field. Please restrict the availability of these records to those persons in your employ who have the training and experience to interpret and understand the information contained in them. These ethical and legal responsibilities are yours. The provider or author of these records can accept no responsibility if this material is made available to any other person or persons who lack such training, or who would not treat it in a professionally responsible manner, or who otherwise should not have access to it, *including the patient.* Redisclosure or retransfer of these records is expressly prohibited, and such redisclosure may subject you to civil and criminal liability. Federal and State laws restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. My signature below authorizes the payment, directly to Family Bridges Therapeutic Associates LLC of benefits payable under my policy. I understand that such payments will be credited to my account with this provider. I further understand that I am financially responsible to this provider for charges not covered or reimbursed by my policy, up to the fee the provider has agreed to accept.

Medicare/ Medicaid patients: I request that payment of authorized benefits be made to Family Bridges on my behalf. I authorize any holder of this medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

I affirm that everything in this form that was not clear has been explained to my satisfaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of client/ guardian Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Therapist Printed Name Date

# Family Bridges Therapeutic Associates

635 South Hazard Street Georgetown, SC 29440

Phone 843-240-1782, 843-240-1783

Fax 1-888-282-6745

###### What You Should Know About the Therapist and Confidentiality and Ethics in Therapy

Melissa Muse EdD LPC-S Angie Dosemagen MEd LPC

SCLPC#2413 LPCS#3295 SCLPC#3751

CBT Trauma Focused Counseling CBT Trauma Focused Counseling

Cognitive Behavioral Approach Cognitive Behavioral Approach

Specializing in Child Sexual Abuse Child & Adolescent Counseling

Child Trauma/ PTSD Specializing in Child Trama/Sexual Abuse

Professional Training Family Reunification

Outcome Measures Educational Consultation

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. **When you or other persons are in physical danger,** the law requires me to tell others about it. Specifically:

1. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
2. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
3. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
4. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding,** you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

1. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
2. In cases where your emotional or mental condition is important information for a court's decision.
3. During a malpractice case or an investigation of me or another therapist by a professional group.
4. In a civil commitment hearing to decide if you will be admitted to a psychiatric hospital.
5. When you are seeing me for court-ordered evaluations or treatment. This includes family court and cases involving DSS information will be shared. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

3. There are a few other things you must know about confidentiality and your treatment:

1. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.
2. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you. HIPPA provides you rights on what information is disclosed in your clinical record.

4. Here is what you need to know about confidentiality **in regard to insurance and money matters:**

Fees for services are as follows (unless otherwise negotiated by contract)

Individual therapy - $120.00/hour Group therapy - $70.00/hour Affidavits - $120.00/hour Assessments - Beginning at $250.00

Family therapy - $130.00/hour Supervised Visitation-$120.00 Consultation - $120.00/hour Testimony - $120.00/hour Depositions - $120.00/hour

All other services including copying $.25 per page and hourly fee , phone contact over 5 minutes - $120.00/hour Travel – please contact business manager to discuss travel expenses for court, therapy, etc.

 Page 2

1. If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or other companies usually want only your diagnosis, my fee, the dates we met, and sometimes a treatment plan. Managed care organizations, however, ask for much more information about you and your symptoms, as well as a detailed treatment plan.
2. I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information at the insurer's office. You cannot be required to release more information just to get payments.
3. If you have been sent to me by your employer or your employer's Employee Assistance Program, either one may require some information. Again, I believe that employers and companies will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.
4. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

5. **Children and families create some special confidentiality questions.**

1. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to *general* information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others' actions put them or others in any danger.
2. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.
3. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.
4. If you and your spouse have a custody dispute, or a court custody hearing is coming up, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
5. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
6. At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 7b, below.)

6. **Confidentiality in group therapy is also a special situation.**

In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.

7. **The relationship between Therapist and Client is a professional one. At no time should our relationship be more**

 **than client and therapist. This includes friendships and sexual relationships and/ or intimacy.**

8. Finally, here are a few other points:

1. I will not record our therapy sessions on audiotape or videotape without your written permission.
2. If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies, which you can see so you will know what is involved.
3. Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Situations that are not mentioned here come up only rarely in my practice. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally.

The signatures here show that we each have read, understand, and agree to abide by the points presented above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Signature of Therapist Date