soul & psyche
COUNSELING SERVICES, LLC

Private-pay Adult

REGISTRATION FORM

Patient Information

Name:	Home Phone: ( )
Street Address:	Mobile Phone: ( )
City, State, Zip:	Email:
Date of Birth:	Emergency Contact Name:
Social Security #:	Emergency Contact #:
Legal Gender: ☐ M ☐ F	Emergency Contact relationship:
Primary Physician:	Marital Status:
Employer:	Spouse Name:

Responsible Party (leave blank if same as patient)

Name:	Home Phone: ( )
Street Address:	Mobile Phone: ( )
City, State, Zip:	Date of Birth:
Relationship to patient:	Social Security #:

401 S. Mechanic St., Jackson, MI 49201 517.201.1121 517.244.8707
marci@soulandpsychecounseling.com www.soulandpsychecounseling.com

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FINANCIAL AGREEMENT

I understand I am completely responsible for any and all costs associated for services provided to me, my dependents, or other person for whom I have assumed financial responsibility. By signing this release I acknowledge I will be paying for services directly because either I have chosen to opt out of utilizing my existing medical insurance coverage for this service or I currently do not have insurance coverage. I understand that Soul & Psyche Counseling Services will not retroactively submit a claim to an insurance provider for services rendered.

Standard fee for self-payment is $100 for one-hour session and $75 for 45-minute session due at the time of service. Payment can be check, cash, or credit card. Appointments missed without canceling will require a $50 fee. Cancellations with less than 48 hours notice may require a $50 fee unless rescheduled within the week.

Credit Card Authorization:

Credit Card Information	*I authorize Soul & Psyche Counseling Services, LLC, to use the credit card information below to pay any invoices (i.e., professional services and cancellation fees) for my account and can request copies of invoices at any time. I understand that my information will be saved for future transactions, and this authorization will remain in effect until cancelled. I certify that I am an authorized user of this credit card and that I will not dispute any payment with my credit card company so long as transactions correspond to terms indicated in this form. I will notify my provider of any changes to this information.*
Card Type: ☐ Mastercard ☐ Visa ☐ Discover ☐ American Express	
Cardholder Name (as on card):	
Card Number:	
Expiration Date (mmyy):	
CVV:	

_____

Patient Name (please print)

_____ _____

Patient or Guarantor Signature Date

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INFORMED CONSENT

Benefits/risks to therapy:

Outcomes of therapy cannot be guaranteed and will only be offered with your consent and within your provider's scope of ability to meet your needs. Benefits include improved relationships, resolution of current conflicts, relief from symptoms, changed behavior, etc. The course of therapy can be uncomfortable, however, especially at the beginning as you remember unpleasant events, feelings, or thoughts. Symptoms may get worse for a short time, and if so, it is important to tell your provider. Some change is quick, but other changes are gradual and frustrating.

Ending treatment:

Usually treatment ends at a mutual and agreed-upon time. However, there are exceptions. If a provider determines s/he is not the best person to meet your clinical needs or is not being clinically effective, reasons for that determination, referrals and resources will be discussed with you. If you commit violence to, verbally or physically threaten any providers, treatment may be terminated immediately. Failure or refusal to pay for services after a reasonable time is another condition for termination.

Emergencies:

Because Soul & Psyche is a limited practice, there is no 24-hour emergency or "on call" coverage. If a crisis or emergency (such as new or worsening thoughts of self or other-directed harm) arises, you may leave a phone message for your provider but do not wait for your provider to call you back. Instead, do one of these things:

- Dial 911 or go to the nearest emergency room
- Call or go to Lifeways Community Mental Health Center (1200 N. West Ave. Jackson, 517-789-1200)
- Call or go to Henry Ford Allegiance Access Center (Anderson Bldg at HF Allegiance Hospital, 517-205-5971)

If your provider is out of town for a period of time, contact with a colleague may be provided for urgent needs.

Consent to treatment:

I voluntarily agree and consent to participate in diagnostic and treatment services provided by Soul & Psyche Counseling Services, LLC, for myself or my dependent (in which case I attest I have legal custody and am legally authorized to consent for treatment on behalf of the patient). I realize that I may refuse any aspect of treatment but that repeated refusal may, in some instances, result in termination of services. I understand that if my provider assess that s/he is not the best option to meet my clinical needs, I will be provided resources and referrals to continue treatment elsewhere.

_____

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_____ _____

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PRIVACY POLICIES

Social Media/Technology policy:

Friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) may compromise your confidentiality and blur the boundaries of therapy and will not be accepted by your provider. Email and text communication are not completely confidential. Please notify your provider at the beginning of treatment if you would like to avoid these forms of communication. Otherwise, signing this form gives your permission to be contacted by mail, telephone, or email to discuss scheduling, billing/payment, and other questions related to your services.

Confidentiality

As a therapy client, you have privileged communication with your provider. All information shared in sessions and any written records are confidential and may not be released without written consent or when the law requires. The law requires disclosure of confidential information in cases of suspected child or elder abuse/neglect and when a client presents a serious risk to self or others. Your provider will inform you if information must be shared and will explore all other options with you before the step is taken.

Minor patients: The law allows parents to have access to their dependents' records. Your child's provider requests that you not ask questions about specific information shared in sessions and will instead meet with you periodically to discuss progress and any concerns. If your child is as serious risk to self or others, you will be notified.

HIPAA

Soul & Psyche Counseling Services, LLC, is required by law to provide you access to a copy of the HIPAA Notice of Privacy Practices so you can understand your rights and protections related to the use and disclosure of your identifiable health care information. You may obtain a copy of the notice from your provider or use this link to view the HIPAA Notice of Privacy Practices: https://www.michigan.gov/documents/HIPAA_Plans_Privacy_Notice_61312_7.pdf

My signature acknowledges receipt of the HIPAA Notice of Privacy Practices. I understand that if I have questions, I may direct them to my provider of service and I may always request a copy. I also authorize my Protected Health Information (PHI) to be used in treatment, payment, and health care operations for these services.

_____

Patient Name (please print)

_____ _____

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TELEHEALTH CONSENT

Consent to teletherapy:

I voluntarily agree for myself or my dependent (in which case I attest I have legal custody and am legally authorized to consent for treatment on behalf of the patient) and consent to participate in treatment services provided by Soul & Psyche Counseling Services, LLC, through a secure, HIPAA-compliant video call using Spruce Health. I realize that I must be a resident of Michigan to be eligible for teletherapy services from Soul & Psyche clinicians.

Confidentiality:

The laws that protect the confidentiality of any medical information also apply to virtual psychotherapy. I understand that the video technology used by Soul & Psyche is encrypted to prevent unauthorized access to my private psychological information. Soul & Psyche Counseling Services, LLC, is not responsible for confidentiality breaches when they are caused by client error or lapses in confidentiality that are due to client's actions.

My Responsibilities:

I understand that I am responsible for providing 1) the necessary equipment and internet access for my teletherapy sessions, 2) the information security of my equipment, and 3) a location with sufficient lighting and privacy that has minimal distractions or intrusions. I must also disclose if any other person can hear or see any part of our session before the session begins. I will not make an audio or video recording of any portion of the session.

Limits of virtual sessions:

I understand that teletherapy may not be as complete as face-to-face service and is not a crisis-based service It is the client's responsibility to inform the clinician of any active suicidal or homicidal thoughts or acute mental health problems, such as manic or psychotic symptoms. The clinician will then facilitate an appropriate referral to an in-person provider.

Troubleshooting:

If video services are not available due to an unplanned equipment or service malfunction, sessions will occur via telephone.

Payment:

Secure online payment will be arranged through Square, Inc., a mobile payment company. Your provider will text or email you a link to follow for making online payment, and you will receive an email receipt for payment. Normal cancellation policies and fees apply to telehealth sessions.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

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Adult

QUESTIONNAIRE FOR NEW CLIENTS

Name: _____

Date: _____

How many sessions are you expecting to need? ☐ 1-10 ☐ 10-20 ☐ ongoing

What are your primary challenges that bring you to therapy?

What are you hoping to gain from therapy?

Check any of the following abuses you have experienced in the past or are currently experiencing:

☐ *Physical* ☐ *Emotional* ☐ *Verbal* ☐ *Sexual* ☐ *Neglect* ☐ *Witness of abuse*

List any current medical conditions/illnesses:

List any current medications: *(or attach list)*

Name	Dose	Frequency	Reason	Physician

List any past mental health or psychiatric history/treatment (i.e., past therapy, issues of self-harm or suicide attempts, use of medications):

List family history of mental health or psychiatric issues involving parents, siblings, grandparents, aunts/uncles (i.e., depression, anxiety, suicide attempts):

Describe your strengths and weaknesses:

Name: _____

Date: _____

Please check any symptoms or experiences that you have had in the last month or that others have told you they notice about you…

☐	Nightmares	☐	Persistent, repetitive, intrusive thoughts, impulses or images
☐	Easily startled, feeling 'jumpy'		
☐	Intrusive memories	☐	Feeling thoughts are controlled or placed
☐	Flashbacks	☐	Going without sleep for more than 2 days
☐	Gaps in memory	☐	Racing thoughts
☐	Feeling numb	☐	Excessive spending
☐	Feeling confused as to what is real and unreal	☐	Risky behaviors
☐	Feeling 'outside of yourself,' detached, observing what you are doing	☐	Rapid mood changes
		☐	Binge eating
☐	Fixations/Obsessions	☐	Voluntary vomiting
☐	Repetitive behaviors or mental acts (i.e., counting, checking locks, washing hands)	☐	Excessive exercise
		☐	Lying
☐	Avoiding people, places, activities, or specific things	☐	Manipulation of others to fulfill desires
		☐	Outbursts of anger
☐	Difficulty making friends	☐	Acts of violence toward objects
☐	Difficulty leaving home	☐	Acts or threats of violence toward people/animals
☐	Tremors		
☐	Psychogenic nonepileptic seizures	☐	Unusual sexual behaviors
☐	Strange physical symptoms	☐	Concerns about sexuality or gender identity
☐	Hearing voices when no one is present		Other:
☐	Unusual visual experiences such as flashes of light, shadows, objects		