soul & psyche
COUNSELING SERVICES, LLC

Child / Adolescent

REGISTRATION FORM

Patient Information

NAME: Patient Phone *(if applicable)*: ( )

Street Address: Emergency Contact Name:

City, State, Zip: Emergency Contact #: ( )

Date of Birth: / / School: Grade:

Legal Gender: ☐ M ☐ F Primary Physician: Last 4 of SSN:

PARENT/GUARDIAN 1 NAME: Relationship to patient:

Address (if different): DOB: / /

Email: Phone: ( )

PARENT/GUARDIAN 2 NAME: Relationship to patient:

Address (if different): DOB: / /

Email: Phone: ( )

Custody Arrangement:

Responsible Party *(if same as parent/guardian, just write "parent 1", "parent 2", or "both" next to name)*

Name: Phone: ( )

Address (if different):

Relationship to patient: Date of Birth: / /

Insurance Information *(please present insurance card/s for photocopy)*

Primary Insurance: Policy Holder Name:

Policy/ID #: Policy Holder Relationship:

Group #: Policy Holder Phone: ( )

Policy Holder Employer: Policy Holder Date of Birth:

Policy Holder Address:

Secondary Insurance: Policy Holder Name:

Policy/ID #: Policy Holder Relationship:

Group #: Policy Holder Phone: ( )

Policy Holder Employer: Policy Holder Date of Birth:

Policy Holder Address:

401 S. Mechanic St., Jackson, MI 49201 517.201.1121 517.244.8707

marci@soulandpsychecounseling.com www.soulandpsychecounseling.com

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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 for my child or dependent to participate in diagnostic and treatment services provided by Soul & Psyche Counseling Services, LLC. I attest that 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 the provider assesses that s/he is not the best option to meet my dependent's clinical needs, I will be provided resources and referrals to continue treatment elsewhere. I have reviewed this form with my child or dependent.

_____
Patient Name (please print)

_____
Parent or Guardian Name (please print)

_____ _____
Parent or Guardian Signature Date

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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.
The law allows parents to have access to their dependents' records; however, your 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 or dependent is a serious risk to self or others, you will surely 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)

_____
Parent or Guardian Name (please print)

_____ _____
Parent or Guardian Signature Date

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FINANCIAL AGREEMENT

Fees:

Some or all of the appointment fee may be covered by insurance. However, insurance often requires copayment (set amount), coinsurance (percent), or deductible amounts. It is your responsibility to verify the specifics of your coverage. You also have the option to self-pay if you prefer to opt out of utilizing insurance coverage or have no insurance coverage. Payment can be check, cash, or credit card and is due at the time of service.

Cancellation:

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. When therapy becomes difficult it can be easy to avoid attending sessions; talk about these feelings with your provider.

Billing Insurance:

In order to submit a claim for services covered under your insurance policy, we must have authorization to release medical information for paper or electronic billing.

By signing below, I acknowledge the following:

1. *I authorize Soul and Psyche Counseling Services, LLC, to file for benefits on my child/dependent's behalf for medical services rendered.*
2. *I authorize the release of any medical information necessary, on paper or electronically, to bill insurance and process my claims.*
3. *I am aware that I am financially responsible for all services not paid by insurance and acknowledge it is my responsibility to know my child/dependent's individual policy (including copay and deductible amounts) and to inform the therapist of any changes to my insurance.*
4. *I am aware that this authorization is valid indefinitely until revoked in writing by myself or by the provider.*
5. *I further authorize that payment be made to Soul & Psyche Counseling Services, LLC on my child/dependent's behalf.*
6. *I release my provider and its' officers, agents, employees, and any clinicians associated with my child/dependent's case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.*

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:	

_____ _____

Parent or Guardian Name (please print) Patient Name (please print)

_____ _____

Parent or Guardian Signature Date

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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

_____ _____

Patient or Guarantor Signature Date

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