Private-pay

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 #:

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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 Alternative Perspective Counseling Services will not retroactively submit a claim to an insurance provider for services rendered. Standard fee for self-payment is $175 for an intake, $150.00 for one-hour session and $110.00 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.

_____

Patient Name (please print)

_____ _____

Patient or Guarantor Signature Date

4295 Okemos Rd. Suite 135, Okemos, MI 48864 517.331.9380 517.331.9381

Vivian@alternative-perspectives.org www.alternative-perspectives.org

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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 APC 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 Community Mental Health Authority of Clinton, Eaton, Ingham Counties (812 E. Jolly Rd. Lansing, 517-364-8200).
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 Alternative Perspectives Counseling, 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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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

Alternative Perspectives Counseling, 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.

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