Congruent Counseling Services, LLC
REGISTRATION FORM

➢ CLIENT INFORMATION

Client Name: (First, MI, Last): _____ **Sex**: □ M □ F

Address: _____ **City**: _____ **ST**: ____ **Zip**: _____

Date of Birth (MM/DD/YYYY): _____ **Email:** _____

Social Security No.: _____ □ Single □ Married □ Other: _____ Employed: □ Y □ N Student: □ FT □ PT

Phones:* Mobile: (_____) _____ Mobile Carrier: _____

Your appointment reminder may be sent by text (if you provide your carrier) or email. Please circle preferred number for calls.*

Home: (_____) _____ Other: (_____) _____

Occupation: _____ Employer: _____ Phone: (____) _____

How did you choose our office? □ Physician □ Insurance □ Website □ Word of Mouth □ Family or Friend

Details: _____

➢ INSURANCE and POLICY HOLDER/SUBSCRIBER INFORMATION

Relationship to client: □ Self □ Spouse □ Parent/Guardian □ Other: _____

***Subscriber* Name**: _____ **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: (_____) _____

➢ PARENT/GUARDIAN INFORMATION *(or other responsible party)*

Relationship to client: □ Self □ Spouse □ Parent/Guardian □ Other: _____ **Sex:** □ M □ F

Name: _____ **Date of Birth:** _____

Social Security No.: _____ Email: _____

Address, if different: _____ City: _____ ST: ____ Zip: _____

Phones: Home: (_____) _____ Mobile: (_____) _____ Business: (_____) _____

Congruent Counseling Services does not bill secondary insurances.
We will provide a statement at your request that you may submit to 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 services 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 pay any deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide service to you.

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. Internet and Email communication carry an inherent risk to privacy;* ***by providing my email address above, I give permission to receive communication, such as reminders and account statements, through email*. By signing below, I indicate recognition and acceptance of these conditions.*

_____ _____ _____

CLIENT/GUARDIAN SIGNATURE **PRINTED NAME** *(if not client)* **DATE**

Congruent Counseling Services, LLC
Fee Schedule and Policies

Psychiatric Interview*	$300	Relationship Counseling*	$110
Medication Management*	$120	Brief Phone Session*	$50
Psychotherapy Interview/Assessment	$150	Crisis Session*	$45
Assessment w/Mark D. Donovan*	$275	Parental Intervention*	$275
Individual/Family/Couples Therapy	$110	Unscheduled Refill Request*	$35
Consultation Only*	$110	Urine Screen – THC or Panel*	$35
Intensive Outpatient Program	$220	Medication Authorization*	$20
Family Group/Parent Education*	$45	Disability/Workers Comp Report*	$300
Report/ Psychiatric Report* (*per half hour*)	$50/$100	Bounced Check Fee*	$25
Letter/Forms*	$25	No Show/Late Cancel Fee (*Indiv/IOP*)*	$60/$100

**These services will not be billed to your insurance by our office. This is not a comprehensive list of all possible charges.*

Cancellation Policy

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 for missed appointments not canceled at least 24 hours prior to the scheduled appointment***. This includes groups – unless prior arrangements are made, you will be expected at the next scheduled group meeting. In the event a courtesy reminder is not made, it *does not excuse* a missed appointment.

Fees and Payment

Fees will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Checks returned for non-payment will result in a $25 bounced check charge. ***Statements are not regularly mailed, and are provided only upon request***. Congruent Counseling Services, LLC will only file reimbursable services with the *primary* insurance. 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.

Failure to Pay

The client agrees that failure to pay the expected service fee 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. ***Client accounts sent to collections for non-payment will be charged the amount owed plus any and all associated 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 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; and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

Court Appearances and Associated Costs

Congruent Counseling Services charges $400 per hour with a minimum of $3,200 for any court appearance whether requested or summonsed, regardless of requesting party. Clients will also be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. Costs incurred by the company for associated legal fees will be passed on to the client. In the case of minors, the signing parent is responsible for this fee unless otherwise pre-arranged with the non-signing parent. A deposit of $3,200 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 $3,200 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 (CCS)and Integrative Counseling, LLC (IC) are separate practices, and as such may require the opening of a separate client chart. The client understands that ***any insurance benefits utilized with CCS cannot be utilized with IC***. IC 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 indicates understanding of the fees and policies as delineated here.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____ Witness Signature _____ Date _____

As of 11/01/2015

Congruent Counseling Services, LLC
Telephone, Email and Teletherapy Policies

Communication, Reminders, Statements

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, the client acknowledges recognition and acceptance of risk to privacy in the use of email and text message.

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 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/Brief Phone 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. Your counselor or therapist has provided you with personal contact information to help 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 taking over five minutes 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.

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 of 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.

I have reviewed and understand these options and I have received a copy of the Telephone, Email 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 your 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 of this Notice.

Client Signature	Date		
Parent/Guardian Signature	Date	Witness Signature	Date

Credit Card Recurring Payment Authorization Form

As a courtesy to you, we can now schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started. Once a month, with this authorization, we will charge the balance due on your account to the credit card you list on file.

You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged once each billing period for the total amount due for that period. The charge will appear on your credit card statement.

Please complete the information below:

I, _____, authorize Congruent Counseling Services, LLC and/or Integrative Counseling, LLC to charge the credit card indicated below once between the 15th and 20th of each month for payment of any balance due for _____.
(name of client or clients)

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Email: _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Is this for a(n): ☐ HSA ☐ FSA ☐ Other Consumer Spending Account?

***For all consumer spending accounts, be advised that if the card cannot be processed, you will be billed and should seek reimbursement from them directly.**

Cardholder Name _____

Account Number _____

Expiration Date _____ CVV _____ (3 digits on back of Visa/MC, 4 digits on front of AMEX)

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

_____ _____

CARDHOLDER 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 PCP that _____ (client name) is being seen by _____ (therapist name). 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 is for the office to complete:

_____ is seeing your patient for

_____

_____

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

Sincerely,

Congruent Counseling Services

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

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

Client Copy

Client Bill of Rights

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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;
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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.

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Congruent Counseling Services, LLC
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