LIVING WELL

COUNSELING SERVICES, LLC

______ New ______ Change

Diagnosis______________________

Therapist Name____________________

Physician Name____________________

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: first middle last

Street Address

City, State, Zip Code

Phone number **Date Of Birth**

Cell phone number **M F** **Sex**

Social Security Number **Email address**

Patient Employer

Employer Address and Phone

S M D W **Marital Status** **Name of Spouse**

BILLING INFORMATION

Responsible Party For Bill (If same as patient, omit)

Street Address (If same as patient, omit)

City, State, Zip Code (If same as patient, omit)

Email address (If same as patient, omit)

Responsible Party's Employer (If same as patient, omit)

Responsible Party's Employer Address and Phone

Nearest Friend or Relative (not at same address) Relationship

Address and Phone Number of above

PRIMARY INSURANCE

Policyholder Name Date of Birth

Insurance Company Name

Insurance Street Address

City, State, Zip Code

Insurance ID# Group #

Living Well Counseling Service will bill the insurance company as a courtesy to the client. The client is ultimately responsible for the payment of all services.

SECONDARY INSURANCE

Policyholder Name Date of Birth

Insurance Company Name

Insurance Street Address

City, State, Zip Code

Insurance ID# Group #

Appointments cancelled with less than 24 hours notice will be billed to the client. Insurance companies do not pay for missed appointment charges

FEE: Your fee will be _________________ per 50 – 60 Min session.

Authorization/Assignment of Benefits: Please sign by the "X" for release of your records to your insurance for medical information necessary to process insurance and for payment to Living Well Counseling Services, LLC by your insurance. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original copy. I understand that partial payments made by insurance carriers are not accepted as full payment for the services rendered and I will be responsible for any charges not covered by insurance. I agree to the stated fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances. I herby authorize said assignee, Living Well Counseling Services, to release all information to secure payment on my behalf.

X____ DATE __________________

Living Well Counseling Services, LLC: **NOTICE OF PRIVACY PRACTICES**
Effective Date: This notice is effective on May 1, 2004.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Our Duty to Safeguard Your Protected Health Information: Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure. We are required to follow the privacy practices described in this Notice.

How We May Use and Disclose Your Protected Health Information: We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment, or our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following offers more description and some examples of our potential uses/disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations. Generally, we may use or disclose your PHI as follows:
For treatment: We may wish to disclose your PHI to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition. We will do so only if you have signed a Release of Authorization for us to provide such information.
To obtain payment: We may disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to the Medicaid/Medicare program and/or an insurance insurer, and HMO, or PPO to get paid for services that we delivered to you.
For health care operations: We may disclose your PHI in the course of operating our program. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.
Appointment reminders: Unless you provide us with alternative instructions, we may call you with appointment reminders and occasionally send materials that may be of interest to you to your home.
Uses and Disclosures Requiring Authorization: For uses and disclosures beyond treatment, payment and operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action.
Uses and Disclosures Not Requiring Consent or Authorization: The law provides that we may disclose your PHI from mental health records without consent or authorization in the following circumstances:
When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or violence, or relating to planned criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.
For health oversight activities: We may disclose PHI to the agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.

Relating to decedents: We may disclose PHI relating to a death to state medical examiners.
To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Your Rights Regarding Your Protected Health Information. You have the following rights relating to your protected health information:
To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.
To choose how we contact you: You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
To inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.
To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; or pursuant to your written authorization. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
To receive this notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.
To complain about our Privacy Practices: If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.
To contact us for information, or to submit a complaint: If you have questions about this Notice or any complaints about our privacy practices, please contact one of the Clinic Directors, Lori Nebel or Debbie Marks at LWCS 4915 Monona Dr. #305, Madison, WI 53716, 608-223-1506.

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Print Client Name | Signature | Date

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Print Guardian Name | Signature | Date

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Print Therapist Name | Signature | Date

PATIENT/CLIENT RIGHTS CONSENT FORM

Please read and sign below.

Living Well Counseling Services, LLC, wants you to be aware of your rights and responsibilities as a patient/client of our clinic. We ask for your INFORMED CONSENT to receive treatment. A copy of the "Patient Bill of Rights" appears in our waiting room and you have been given a copy of the "Patient Bill of Rights" to take with you. Please read this. In addition, please read the following general information about the psychotherapy process:

CONSENT TO TREATMENT:

1. The benefits of psychotherapy are to help alleviate the problems and symptoms that you present. As a client you will be involved in the formulation and evaluation of your treatment plan throughout the therapy process.

2. Psychotherapy is conducted in a professional and appropriate manner between psychotherapist and patient/client talking about the presenting problem.

3. If there is any expected side effects from psychotherapy (or medication when that is a consideration) they will be discussed with you.

4. The psychotherapist will suggest alternative treatment methods and will make referrals to other psychotherapists when appropriate or necessary.

5. The possible consequences of not receiving psychotherapy may be discussed.

6. What you say to your therapist, as well as any case notes or other records are confidential and generally will not be shared with others unless you provide written consent. However, there are exceptions to this. a) Sound ethical treatment as well as state mental health policy requires periodic review of psychotherapy performed by your therapist. These reviews will be done by other mental health professionals affiliated with Living Well Counseling Services unless you are otherwise notified. You have the right, upon your request, to meet face to face with your therapist's clinical supervisor.

b) If your therapist has reason to believe you or someone else may be in danger of physical harm, state law and professional ethics require your therapist to take steps to protect you and/or other persons involved. This may include notification of appropriate social service and legal agencies.

Examples of such instances include:

*Danger of suicide or other self-injurious behavior
*Danger of causing physical harm to another
*Occurrence or suspicion of child abuse or neglect

CLIENT RESPONSIBILITIES:

1. The client will devote time and energy to therapy. The client will follow through with treatment recommendations. This commitment strengthens your chances of reaching the goals of treatment that you and your therapist develop.

2. Refrain from physical or other types of abusive behavior to yourself, to others or to any property.

3. Be honest regarding your thoughts and feelings about your treatment.

4. Keep appointments made. Cancellations with less than 24 hour notice will be charged to your account.

5. Stay current with your bill. Full payment is expected at time of service.

INFORMED CONSENT: I have read the above statements regarding my rights and responsibilities. I hereby give my consent to be assessed and treated by this clinic. I have discussed any concerns I might have about the above statements. I understand that this statement of consent is in effect for twelve months from the date below unless I wish to revoke it earlier.

Patient/Client Signature____ **Date**______________

Parent/Guardian Signature____ **Date**______________

Therapist Signature____ **Date**______________