Registration Form

Jupiter Center for Growth and Healing

Date_____ **DX Code**_____
(For Office Use Only)

Client Information

Patient Name (Print)_____ **Date of Birth**_____
Last Name First Name Initial

Street Address_____ Cell Phone _____ Home Phone _____

City_____ State_____ ZIP_____ Work Phone _____

Soc. Sec. #_____ Emergency Contact_____ Emerg. Phone _____

Sex: __Female __Male Age_____ Marital Status: __ Single __ Married __ Widowed __ Divorced __ Separated __ Other

Employer _____ Occupation_____

Primary Insurance

Primary Insurance Company_____ Phone { }_____

Ins. Claims Address_____ City_____ State_____ Zip_____

Policy/ID #_____ Group/Plan #_____
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
Last name First Name Initial

Address_____ City_____ State_____ Zip_____ **Date of Birth**_____

Soc. Sec#_____ Employer_____

Secondary Insurance

Secondary Insurance Company_____ Phone { }_____

Ins Claims Address_____ City_____ State_____ Zip_____

Policy/ID #_____ Group/Plan #_____
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
Last name First Name Initial

Address_____ City_____ State_____ Zip_____ **Date of Birth**_____

Soc. Sec#_____ Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____ Relationship _____

Address_____ Phone { }_____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____
Client Signature Date

_____ _____ _____
Responsible Party Signature (or parent if client is minor) Relationship To Patient Date

Relationship Status

_____ Single _____ Long-term relationship/partnership for _____ years____ Married for ____ years

_____Divorced for ____years after a marriage of _____ years

_____Separated/Widowed for ___ years after a marriage of _____ years

Name of spouse if currently married) _____ Spouse's Occupation_____

First names and ages of children, if any:

_____

Medical History

Are you currently under medical care? ____ If yes, please indicate reason _____

Physician's Name: _____ Clinic Name: _____

Phone: _____ Fax: _____

Do you (or spouse if couples therapy) take any prescription medications? _____ If yes, what are they?

_____

Other significant medical history: _____

I would like information about my therapy shared with my physician: Yes _____ No _____

Mental Health History

Have you previously seen a counselor/therapist/psychologist/psychiatrist?

Name/Date/Location: _____

Purpose: _____

What are some things gained/learned by your therapy experience:

_____

_____

Was there anything that your therapist did that was not helpful: _____

When was your last appointment with any of the above? _____

Have you ever attempted suicide? _____ Have any family members attempted suicide? _____

If you have any concerns about the possibility of suicide, please let your therapist know immediately, or call 911.

Drug and Alcohol Use

Please check any substances you are currently using:

____ Alcohol ____ Marijuana ____ Cocaine ____ Heroin (Opiates) ____ Ecstasy

____ LSD/Acid ____ Methamphetamine ____ Speed/amphetamines ____ inhalants

In the past year:

Have you ever felt the need to cut down? ____ Yes ____ No

Have you ever felt annoyed by criticism of your usage: ____ Yes ____ No

Have you ever felt bad or guilty about your use: ____ Yes ____ No

Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or reduce symptoms of a hangover: ____ Yes ____ No

How much of the above-checked substances do you use per week on average:

_____

Current Issues

In your own words, why you are seeking counseling now?

_____

_____

_____

How long have these issues or concerns been present for you?

_____

_____

How did you find out about Jupiter Center/Michael Kinzer?

_____

If you were referred by someone, may we thank them? Yes ____ No _____

How would you know if your problem got better?

_____

_____

How would other people know if the problem got better?

_____

Is there anything else you think your therapist should know at this time?

_____

_____

What kinds of support systems (connections) do you have in place?

_____

_____

Clinic Policies

Welcome to our Clinic (Michael Kinzer at Jupiter Center for Growth and Healing). We want to help make your experience with us pleasant and comfortable. Please feel free to ask questions about anything you do not understand.

Client Name(s): _____ Date: _____

Business and Billing Policies

* Therapy sessions are generally 55 minutes, unless otherwise noted.
* We request co-pays to be paid at the time of service.
* Personal accounts must be up to date for appointments to be scheduled.
* A variety of payment options are available for clients not using insurance. Please ask for information.
* I understand that the Clinic will submit claims to my insurance company and I am responsible for any unpaid balance. Benefits quoted by the Clinic were provided by your insurance company and are not a guarantee of payment. We strongly encourage you to contact your insurance company to verify information about your benefits.
* The Clinic is **not** a Medicare provider.
* I agree to notify the Clinic of any insurance change during the course of my treatment.
* I authorize payment of benefits to be made directly to the Clinic for services provided by the Clinic for myself or the above named patient.
* I agree to pay all bills within 30 days after receiving a statement or as otherwise expressly agreed.
* When we have received payment from your insurance company, you will be sent a bill for the balance or a refund check will be issued if more was paid than anticipated.
* If your insurance changes while you are a client here, it is your responsibility to let us know and to give us a copy of your new insurance card.
* I understand that a $25 fee will be assessed for checks returned to us by the bank.
* If it is necessary for us to use collection services to receive payment from you, you will be assessed the amount owed to the Clinic plus the amount charged by the collection service.

Cancellation Policies

I agree to give a 48-hour notice for cancellation or change of appointments. Insurance companies do not pay for appointments that are cancelled or missed. The Clinic will charge clients a fee of $100 for missing a scheduled session and providing less than 48 hours (2 business days) notice of the cancellation, unless their reason for providing late notice was unavoidable and due to illness or a family emergency.

The Clinic may decide to terminate services to clients who miss appointments or make late cancellations.

P*sychological Service Policies and Information*

* Psychotherapy services can accompany potential risks and benefits to clients, depending on the condition, status, and circumstances of the client. It is possible that therapy services can coincide with an increase in psychological symptoms for some time during treatment, including some levels of disruption to family or other relationships. Please feel free to consult your therapist regarding these and other risks you may wish to know more about as you begin therapy at the clinic. Your therapist will be more than happy to answer any questions you may have. If you notice any increase in psychological symptoms, disruption in relationships, concerns for your own safety or the safety of others during therapy, please bring these concerns to the attention of your

therapist right away.

* If the client is a minor, the parent's signature below signifies that this parent is authorized to consent and does consent to the child seeing a therapist at Jupiter Center for therapy services as described in these clinic policies and as sometimes further described by the therapist in session.
* Counseling sessions are 50-55 minutes in length unless otherwise specified.
* Your therapist will usually take from 1 to 4 sessions to evaluate your needs, set goals with you and determine a treatment plan.
* **If for any reason you are not comfortable with your therapist, we will be happy to provide you with referrals to other therapists upon request.**
- Therapists will attempt return calls within 24 hours with the exception of weekends. When leaving messages please indicate times and numbers where you are most easily reached.
- You may email your therapist, but if you need immediate attention, please also leave a voicemail message.
- All intake forms must be completed on your initial visit.
- The information we gather about you will be kept confidential, with some exceptions. As legally mandated reporters, we are required by law to report any instances of suspected abuse or neglect of a minor child or vulnerable adult. We may also be required to report instances in which we have reason to believe a client is a danger to themselves or someone else. For further information about privacy, please review the Notice of Privacy Practices you receive at the time of your intake.
- Children under the age of 10 are not allowed to wait in the lobby while you attend a session, unless previously discussed with your clinician.
- The Clinic is a business separately owned and operated from all other businesses that may share building space with the Clinic.
- If you have any questions at any time about these or other aspects of the Clinic's services you have been provided, please discuss this with your therapist. Please also refer to the Client Bill of Rights you were given at the time of intake.

_____ _____

Client Signature(s) Date

_____ _____

(Parent signature of client is minor) Date

NOTICE OF PRIVACY PRACTICES

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

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. Privacy is one of our highest priorities.

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care and respect. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you. We safeguard information during all business practices according to established security standards and procedures; we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

In the course of doing business, we collect and use various types of information to provide services to you, to process your claims and to bring you health information that might be of interest to you. Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number and address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

We limit who receives information and what type of information is shared. We may share information with our multidisciplinary licensed or certified staff for purposes of consultation or referral and to insure the highest quality and most appropriate care. To help us offer you our services, we may share information with companies that work for us, such as for the purpose of claim processing. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential. Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you we will attempt to notify you (unless we are prohibited from doing so). We are legally mandated reporters, which means we are required by law to report information regarding suspected abuse or neglect of a minor child or vulnerable adult. Except as required by law or as described above, we do not share information with other parties, including government agencies. We will not share any customer information with third party marketers who offer products and services to our patients.

Signed _____ Date _____

Signed _____ Date _____

Assignment of Benefits and Authorization for Release

Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company directly. Minnesota State Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

ASSIGNMENT OF INSURANCE INFORMATION:

I hereby authorize assignment of benefits and payment of medical/mental health
benefits to Michael Kinzer for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due for charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize
refunds to my insurance company for any overpaid benefits. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION:

I hereby authorize Michael Kinzer to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

Client Full Name (printed) _____

_____ _____
Client Signature Date

_____ _____
Responsible Party (parent if client is a minor) Date

Client Bill of Rights

consumers of marriage and family therapy services offered by marriage and family therapists licensed by the state of Minnesota have the right:

to expect that a therapist has met the minimal qualifications of education, training, and experience required by state law;

to examine public records maintained by the Board of Marriage and Family Therapy that contain the credentials of a therapist;

to report complaints to the Board of Marriage and Family Therapy;

to be informed of the cost of professional services before receiving the services;

to privacy as defined and limited by rule and law;

to be free from being the object of unlawful discrimination while receiving services;

to have access to their records as provided in Minnesota Statutes, sections 144.291 to 144.298, except as otherwise provided by law or prior written agreement; and

to be free from exploitation for the benefit or advantage of a therapist.