CLIENT REGISTRATION & INFORMATION

Monica D. Klisz, LPC
Counseling for Recovery, Growth & Wellness

Please complete prior to first appointment.

Name: ___________________________________Gender and preferred pronoun: _____________________

Address: ____

City: ______________________________ State: ______________________ Zip: ____________________

Best Contact Number: _____________________________ Date of Birth: ___________________________

Email: ____(___ email or ___ text reminders?)

Emergency Contact: ____________________ Phone: _____________ Relationship: __________________

Occupation: ____________________________________ Employer: ____________________________

Marital Status: Single ____ Married: ____ Divorced: ____ Widowed: ____ Education Level: __________

Referral: ____

Responsible Party: ______________________________ Relationship:______________________________

Please complete the following section if you wish to access insurance benefits for services received at Counseling for Recovery, Growth & Wellness.

Primary Insurance Carrier: ____

ID #:____________________________________ Group #:_______________________________________

Subscriber Name: __________________________________ Date of Birth:__________________________

Subscriber Employer: ____

Insurance Company Address: ___________________________ Insurance Co. Phone Number:_________

** Note: We will bill most insurance companies as a courtesy to you; however, the signed responsible party is ultimately responsible for payment of this account.*

Medical History
*Primary Care Physician Name: ________________________________Phone:________________

Last Visit: _____________________ Reason: ____

Weight: _________ Height: ________ Medical Conditions: _________________________________

Allergies: ____

***Psychiatrist N**ame: ____Phone:________________

Please list all prescribed and over the counter medications:

Medication	Dosage	Prescribing MD	Date Prescribed	Reason Prescribed

Have you been seen by a mental health professional in the past for assessment, testing, medication or counseling. If yes, please explain:
____

____

Have you ever been hospitalized for medical or psychiatric reasons? Yes ___ No ____

If yes, please provide the following information:

Date Facility Name & Location Reason
____

____

*** Please sign Consent for Disclosure in order to allow for coordination of care.**

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Briefly state your goals for therapy:

____

____

Please check any of the following you have experienced: Circle any of the above you have experienced in the past 6 months.

__ Health Problems
__ Frequent Crying
__ Memory Difficulties
__ Trauma/abuse
__ Substance Abuse
__ Nightmares
__ Allergies
__ Eating (anorexia/bulimia/binge)
__ Suicidal
__ Head trauma
__ Problematic Anger
__ Drug/Alcohol Difficulties
__ Depression
__ Sexual issues/concerns
__ Suicidal Thoughts
__ Headaches
__ Self-control difficulties
__ Self-Harming Behaviors
__ Sleep (onset/maintenance)
__ Low Motivation
__ Fatigue/low energy
__ Marital Difficulties
__ Weight Loss/Gain
__ Obsessive Thoughts/Behaviors
__ Addiction: ________________
__ Parenting Difficulties
__ Concentration/Focus Issues
__ Social Difficulties
__ Grief/loss
__ Gender/sexuality
__ Anxiety
__ Loneliness
__ General Stress
__ Psychosis
__ Employment/Career
__ Other:__________________
__ Adoption
__ Brain Injury
__ Other:__________________

Please check any of the following that have been present in the family (including extended family on mother and father's sides).

__ Drug/Alcohol Abuse
__ Learning/Developmental Disabilities
__ Anger/violence
__ Sexual Abuse
__ Mental Illness
__ Eating Disorders
__ Physical Abuse
__ Suicide
__ Attention Deficit

Please estimate the severity of your current problem(s) using the scale below:

Mild: ____ Moderate: ____ Severe: ____ Extremely Severe: ____ Incapacitating: ____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Counseling for Recovery, Growth & Wellness (part of MDK, LLC) is required by law to maintain the privacy of protected health information. We are required to notify you of our legal duties and privacy practices with regard to protected health information. We are required to adhere to the terms of this notice. We will handle your protected health information only as allowed by the federal and state law according to the practice's policies, using the most rigorous law that protects your health information.

Each time you receive services from Counseling for Recovery, Growth & Wellness, your provider makes a record of the visit. This record contains assessment information, diagnoses, any changes in functioning, interventions, plans for future care or treatment, and billing-related information. You should be aware of the following rights concerning your protected health information.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Counseling for Recovery, Growth & Wellness you have the right to:

Inspect and Copy: You have the right to request to inspect and/or obtain a copy of your medical record. You must make the request via your provider or owner of Counseling for Recovery, Growth & Wellness. The right is not absolute. If access could cause harm, your request can be denied. If denied, you will be given a timely written notice that includes reason for denial. The notice will become part of your record.

Amend: You have the right to request an amendment of your medical record if you believe the information in the record is inaccurate or incomplete. You have the right to request an amendment for as long as the information is kept by or for Counseling for Recovery, Growth & Wellness. The request must be made in writing to Counseling for Recovery, Growth & Wellness. We reserve the right to deny your request for appropriate reasons and you will be provided a written explanation.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This pertains to disclosures we make of your health information for purposes other than treatment where an authorization was not required.

Request Restrictions: You have the right to request from your provider a restriction regarding the use or disclosure of your protected health information. Your request will be given serious consideration. You will be promptly informed as to whether we can honor the requested restriction while continuing to offer effective services, receive payment and maintain health care operations. We are not legally required to agree to your request. If we agree to do so, we are bound by agreement except under certain emergency situations.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of our home. Counseling for Recovery, Growth & Wellness will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services and related correspondence. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice at any time upon request. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Upon signing Counseling for Recovery, Growth & Wellness' consent form and financial agreement you are allowing us to see the disclosure and necessary information about you within the practice and with business associates in order to provide treatment/services, receive payments and conduct day to day health care operations. Some examples of this are listed below.

Fair Treatment: We may use and disclose health information about you via consultation with other providers in an effort to render the best possible services to you.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, the designated responsible party or a third party insurance payer. If applicable, we may also tell your health plan about treatment you are going to receive to determine whether your plan will cover services.

For Health Care Operations:
- In scheduling efforts
- Other professional staff within the office may view or handle your chart in the course of daily office operations. When disclosing information, primarily appointment scheduling and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Emergencies We may use or disclose necessary protected health information about you in an emergency situation. In the event that this occurs, we will notify you as soon as reasonably possible.

Specific Circumstances for Disclosures Federal and state law allows Counseling for Recovery, Growth & Wellness to disclose health information about you in the following specific circumstances:
- Help with public health and safety issues, preventing disease, reporting suspected abuse, neglect or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety
- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies
- Address workers' compensation, law enforcement, and other government requests: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law;
- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We will never sell your information, use your information for marketing or fundraising.
- In most circumstances we will not share psychotherapy notes.

Substance Abuse Regulations The use and disclosure of protected health information for substance abuse patients is subject to additional regulations under federal law. Some regulations may prohibit the uses and disclosures provided in this notice. If such a case occurs, adherence to the more restrictive regulation will apply.

Other Uses of Health Information Other uses and disclosures of health information not covered by this notice or the laws that apply may be made only with your written permission. If you provide permission to disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain your records of the care provided to you.

Changes to Privacy Practices We reserve the right to change this notice at any time.

For additional information concerning our Privacy Policy or the federal and state laws pertaining to our policy, please contact:
Monica D. Klisz, LPC, Counseling for Recovery, Growth & Wellness
3111 Northside Avenue, Suite 101
Richmond, VA 23226
804-366-4330

Regional Advocate
Virginia Secretary of Health & Human Services
202 North 9th Street, Suite 622
Richmond, VA 23219
804-786-7765

Secretary of Health and Human Services
Hubert Humphrey Building
2000 Independence Avenue, SW
Washington,DC 20201
202-690-7000

Your signature below indicates that you have received and read this privacy notice.

____ _______________________
Signatures Date

INFORMED CONSENT FOR TREATMENT

I, ___________________________, do voluntarily consent to the professional services provided by Monica D. Klisz, LPC. I understand that therapy, like other healing arts, is not an exact science and no guarantees are made as a result of evaluation and service provision.

I understand that this process carries inherent risks to my sense of well being, like everything in life, and that I may experience emotional discomfort or psychological pain as a part of the treatment and growth process. I recognize and accept that it my responsibility to communicate any such occurrences to Monica D. Klisz, LPC, and I accept this as a reasonable risk.

In the event that I should ever feel the risks of the professional services provided outweigh the benefits, I will immediately bring this to the attention of Monica D. Klisz, LPC. I understand that I can withdraw my consent at any time for any reason and that I can refuse any service that I wish for any or no reason.

I understand that information shared by me and material kept in my formal client file will remain confidential unless I give written permission for its release or there is a legal requirement for its release. Samples of such legal requirements include but are not limited to: 1) a strong indication of abuse or neglect to a child, elder, or dependent adult, 2) a strong indication that I am currently a danger to myself or others, 3) a strong indication that I have a sincere plan to harm myself or others in the immediate future.

I also understand that professional counselor ethics require that counselors not practice in isolation and that my counselor may consult with other professionals about my case. It is my understanding that identifying information about me will not be revealed and that such consultations shall occur in instances where my counselor feels it will benefit the work with me.

My signature given here indicates that I have read carefully and completely this informed consent. I understand each part completely and have no questions about any part at this time. I understand the nature and limits of the professional services offered, as well as the nature and limits of confidentiality, and I am in agreement with this document as it is written at this time. Should a question or concern arise, I agree to inquire about it in person as soon as I become aware of it and before the next service provision whenever possible.

- I am aware of scheduling policies; fees to be charged; policies regarding missed appointments; and if applicable, matters related to insurance.

- I acknowledge that I have been given the Counseling for Recovery, Growth & Wellness Notice of Privacy Practices.

I have read and fully understand the above and give consent for treatment.

______________________________________ ______________________
Signature Date

INFORMATION TECHNOLOGY POLICIES

Please read each of the following policies carefully. These policies exist to protect your personal information and to maintain appropriate professional therapeutic boundaries. They are informed by professional counseling ethics, Commonwealth of Virginia law, and my own understanding of best practices for my occupation.

Text Messaging Policy
I use text messages in instances of arranging or confirming appointments with clients or when a client must alert me they are running late or have a scheduling issue. In such an instance, I will respond to acknowledge receipt and address the scheduling issue. It is my policy not to provide counseling or consultation to clients via text messaging. It is also mutually understood that texting is not a secure form of communication and privacy and confidentiality cannot be guaranteed.

By initialing here, you indicate that you understand my text messaging policy and agree to adhere to it as described ___

Telephone & Automated Voice Messaging Policy
I could call you for a variety of professional reasons including 1) to provide an appointment reminder, 2) to provide a brief fifteen (15) minute phone consultation, 3) to return a phone call you have placed to me. Note that these are only sample reasons I may call, though any reason shall be professional in nature. In the event that I call you and you do not answer, I will leave a voice message if such a feature is available.

By initialing here, you agree to allow me to call and leave voice messages for professional reasons ____

In the event that I call you and someone other than you answers the phone, I will ask to speak with you. If they ask who is calling, I shall provide my name but not my title or credentials. If they inquire about my reason for calling, I shall not provide a reason without your permission. It is best if you help me understand who could potentially answer and instruct me if I am to speak with this person or not. In any case, I will not reveal you are receiving services from me even with your consent to do so.

By initialing here, you agree to allow me to call and ask to speak with you for professional reasons ____

Email Policy
I am willing to correspond with you by email for limited purposes. Such emails shall be professional in nature and generally limited to 1) scheduling appointments, 2) providing supportive comments or feedback, 3) responding to specific administrative or consulting requests not of a psychotherapeutic nature. Note that there may be other professional purposes that may be suitable and these are samples.

It is also important to note that 1) I shall not provide professional counseling services by email, Skype, or any other computer or internet device, 2) emergencies shall not be addressed by email with the above noted exception of scheduling, 3) I shall not accept any forwarded emails from clients or any emails from clients not professional in nature including but not limited to chain letters, links to websites, or multiparty ad hoc discussion forums, 4) I do not wish to be carbon copied (cc) or blind carbon copied (bcc) on any email. In the event that you have an email, forward, or other piece of online information you wish to share with me, please bring it in person to our next appointment.

It is also mutually understood that email is not a secure form of communication and privacy and confidentiality cannot be guaranteed.

By initialing here, you indicate that you understand my email policy and agree to adhere to it as described ___

Social Media Policy
I do not currently participate in social media services with clients (e.g., Facebook, Twitter, Google+, LinkedIn, and similar sites and services). Any requests to join such a network will be declined. Please understand that this is a matter of professional counseling boundaries and best practice and not a reflection on your desirability as a friend. Our professional relationship prohibits us from being friends, even in the social media sense of the term.

By initialing here, you indicate that you understand my social media policy and agree to adhere to it as described ___

My signature given here indicates that I have read carefully and completely the above policies. I understand them completely and have no questions at this time. Should a question arise, I agree to inquire about it in person before acting.

____ ____________________
Signature Date

FINANCIAL AGREEMENT

Current Fee Schedule

Initial Visit/Assessment (60 minutes)	$125.00
Individual Therapy (55 minutes)	$ 100.00
Group:	$ 40.00/session
No Show/Late Cancel:	Full fee (copay plus insurance amount)
Returned Check:	$ 30.00
Telephone session:	$100.00/hour (not reimbursable by insurance)
Correspondence/Collateral	$50/half hour

Payment Source:____________________ Copay: ____________ Deductible: ________

PAYMENT DUE AT THE BEGINNING OF EACH SESSION: CASH, CHECK or CREDIT CARD.

A portion of these charges are generally reimbursed by insurance policies. Please note that some insurance companies require authorization for services prior to the initial session. Therefore, it is important for you to contact your insurance company to verify your benefits, determine any deductible and/or co-payment amounts that may apply and to obtain any required initial authorization for services. Counseling for Recovery, Growth & Wellness will bill most insurance companies as a courtesy to you.

A minimum 24-hour notice is required to change or cancel an appointment. If you do not cancel within that allotted time or you miss your appointment you will be responsible for the full cost of the appointment. There will be a $30 charge on returned checks. These charges cannot be filed to insurance companies and therefore are your full responsibility. Payment must be received prior to scheduling another appointment.

Payment is required at the time of service for the portion of your bill not covered by insurance. Any and all charges not paid by your insurance company will become your full responsibility. This includes any payment not received from your insurance company within 90 days from the date of the claim being submitted. Telephone sessions are not reimbursable by insurance and can be arranged for a private fee. There will be a charge for correspondence or collateral contact that goes beyond 15 minutes.

Out of network policies will be paid in full at the time of service and billed to the insurance company with reimbursement directly to the client.

In the event that your account has to be turned over to collections because of non-payment, any and all costs associated with collection efforts will be your responsibility.

I authorize Monica D. Klisz, LPC of *Counseling for Recovery, Growth & Wellness* to release to my mental health plan any and all information which it deems necessary to insure prompt payment of all charges for services provided. I also assign the payment of all insurance benefits directly to Monica D. Klisz, LPC of *Counseling for Recovery, Growth & Wellness* for any and all charges incurred in connection with services provided.

I have read and fully understand the above and accept treatment under these terms.

____ ____________________

Signature of person responsible for payment Date