

# Client Registration (Couple)

## CLIENT A:

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email (optional) \_\_\_\_\_

Emergency Contact Info \_\_\_\_\_

## CLIENT B:

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email (optional) \_\_\_\_\_

Emergency Contact Info \_\_\_\_\_

By signing below, I affirm that I understand the basic ideas, goals, and methods of this therapy. With enough knowledge, and without being forced, I enter into treatment. The therapist has addressed my questions and/or concerns regarding confidentiality and the therapy process. I understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this therapist's willingness to use and share his or her knowledge and skills in good faith. Periodically during treatment, we will evaluate progress and may change treatment goals as needed. If it becomes clear that there is a need to transition care to another therapist for any reason (e.g., the nature of symptoms being addressed, misfit of personality, lack of progress etc.) I agree to discuss these concerns with my therapist and to participate in planning for transition to a new therapist if the issues cannot be resolved.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party.

I understand that 24-hour notice is required for the cancellation of a session. If 24-hour notice is not given, I understand that I may be responsible for a fee of \$135, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.

By signing below you are consenting to receiving the psychotherapy services of PeoplePsych, LLC.

Client A Signature \_\_\_\_\_ Date \_\_\_\_\_

Client B Signature \_\_\_\_\_ Date \_\_\_\_\_

# Notice of Privacy Practices (Brief Version)

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

## Our Commitment to Your Privacy

Please note that PeoplePsych is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our patients' personal information. You can be assured that our practice goes beyond what is required by HIPAA.

We are dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. This form is a summary of the full Notice of Privacy Practices (NPP) which is available if you would like more information.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services and for some other business activities which are called, in the law, health care operations. After you have read this NPP and discussed it with your therapist we will ask you to sign a Consent Form to allow us to use and share your information as needed. Please note that PeoplePsych will continue to have your complete releases of information in addition to this document. If you do not consent and sign this form, we cannot treat you.

PeoplePsych utilizes an electronic billing service to process claims via the internet. Our office has taken great care in selecting the billing company with whom we have contracted. Each step in the process is encrypted to ensure the highest standard in privacy regarding sensitive personal information.

If there is a need to disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this. Of course we will keep your health information private, but there can be rare times when the law requires us to use or share it. Some example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

## Questions or Complaints

You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer listed below and with the Secretary of the Department of Health and Human Services by visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/), sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, or calling 1-877-696-6775. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

**Erin Johnston, LCSW**  
**PeoplePsych, LLC Privacy Officer**  
**312-448-7218 x701**

## Email and Voicemail Consent (Each client must circle yes or no and sign)

**YES NO** PeoplePsych, LLC may communicate with me about billing and scheduling via email. If "yes", I understand that PeoplePsych cannot guarantee the security of email communication especially related to treatment information. I further understand that my Personal Health Information (PHI) may be at risk if I chose to communicate with my therapist via email about treatment and I assume sole responsibility and liability for this risk.

**YES NO** PeoplePsych, LLC may leave a message on client's/family voicemail confirming your appointment and/or to provide information you requested regarding your treatment.

**Signature Client A:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**YES NO** PeoplePsych, LLC may communicate with me about billing and scheduling via email. If "yes", I understand that PeoplePsych cannot guarantee the security of email communication especially related to treatment information. I further understand that my Personal Health Information (PHI) may be at risk if I chose to communicate with my therapist via email about treatment and I assume sole responsibility and liability for this risk.

**YES NO** PeoplePsych, LLC may leave a message on client's/family voicemail confirming your appointment and/or to provide information you requested regarding your treatment.

**Signature Client B:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Responsibility for Fees & Credit Card Authorization Form

PeoplePsych's standard therapy sessions (for individual, couple, and family sessions) are 55-60 minutes in length and fees are as follows:

- Initial Session - \$160.00
- Subsequent Sessions - \$135.00

Longer sessions are available upon request and will result in an additional fee. In some cases, fee for service clients may negotiate a lower rate for sessions by first speaking with their therapist who will discuss the request with the PeoplePsych billing department.

We require 24 hours notice of any cancellation. Clients may otherwise be charged the full session fee. Insurance does not cover missed sessions. Rates may increase periodically; clients will be informed prior to any rate change.

All client fees are due at time of service. Payment may be made by cash, check, PayPal or credit/debit card.

\_\_\_\_\_

I hereby acknowledge that I am personally liable for all fees for services performed on my behalf by PeoplePsych LLC ("PeoplePsych"). These fees include full session charges.

I hereby authorize the credit card company listed below to recognize and approve charges against the credit card listed below as submitted by PeoplePsych. I certify that the below listed card is issued to me, and/or that I am an authorized signatory on the account; and that said card is currently valid. I further agree to maintain and keep on file with PeoplePsych a valid credit card at all times.

This credit card authorization form is kept on file for billing purposes and is used only as requested by card holder or in the event that an outstanding bill is not paid after seven (7) days notice that it is due. As stated in the client agreement, all fees are due by check or cash at the time of service.

Client Name \_\_\_\_\_

Name on Credit Card \_\_\_\_\_

Type of Card     **VISA**             **MasterCard**             **AMEX**             **Discover**

Credit Card No. \_\_\_\_\_

Expiration Date \_\_\_\_\_ CVC\* No. \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Phone \_\_\_\_\_

I understand that this card will only be used to receive payment for services received from and billed by PeoplePsych, LLC to client named above. I agree to pay the charges for which I am billed if I have chosen not to pay using another form of payment.

Authorization Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*CVC: A Card Verification Code, or CVC, is a number that provides extra security to credit and debit card holders, in case an unauthorized person gets a hold of your account number. CVCs are one way to make sure someone has the actual card in his or her possession.

The CVC on American Express cards is four digits, and is located on the front of the card, on the right side. Discover, MasterCard, and Visa use three-digit CVCs, which are listed on the back of the card. The CVC is the last three digits of the number that appears on your signature bar.