Family – Individual Participant Registration

Every participating family member over the age of 12
must complete and sign a copy of this form *before* the initial session.

CLIENT FAMILY NAME (i.e. Smith Doe Family) ____

Client Name ____ Age _________ Gender ________

Home Address ____

City ____ State __________ Zip ____________________

Birth Date ____________________________ Pronouns _________________________________

Phone: __________________________ Relationship to Client Family _________________________________

Email ____

Emergency Contact (name and phone number) ____

- I affirm that I understand the basic ideas, goals, and methods of this family therapy. I believe I have adequate knowledge and I voluntarily and without coercion enter into this family therapy.
- The therapist has addressed my questions and/or concerns regarding confidentiality and the therapy process, and the limitations of confidentiality inherent in family/group therapy. I understand that neither the therapist or PeoplePsych, LLC is responsible (legally or ethically) for confidentiality breeches by other family therapy participants. I understand PeoplePsych, LLC does not have control over the action of other therapy participants.
- I understand that no guarantees regarding the outcome of therapy can or have been given.
- This agreement shows this therapist's willingness to use and share their 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 certifies that:
  1. I understand payment for each session is governed by agreement amongst therapy participants and is secured by the person whose name appears on the credit card agreement and based on any other agreement reached with the therapist;
  2. I understand that as a fee per service therapy payment is due and expected at the end of each session;
  3. understand that fees may not be split among therapy participants.
- If I am unable to or do not wish to participate in a scheduled session, I understand that the other family members might have a therapy session without me. I agree to such sessions being conducted and that established payment methods are followed.
- I understand that 24-hour notice is required for the cancellation of a therapy session. If 24-hour notice is not given, I understand that the client family may be responsible for the full session fee which may be as high as $165 and that this charge is due in full at the time of the missed session. The only exceptions are unforeseen or unavoidable situations arising suddenly and determination is at the discretion of PeoplePsych administration.

By signing below you are consenting to receiving the family therapy services of PeoplePsych, LLC, under the terms above.

Client 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 you 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/, 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 (you 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.

Client Signature: ____ Date: ___________________