Re=Generation Therapy and Counseling
Chaplin, CT 06235

CLIENT INTAKE FORM

Today's Date _____/_____/_____ **Therapist:**_____

CLIENT INFORMATION

Client's *First* Name	Middle	Last	✈ Mr. ✈ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ✈ Yes ✈ No	If not, what is your legal name?	(Former Name)	Birth Date	Age

Street Address	City	State	ZIP Code	Home Phone No.
P.O. Box	City	State	ZIP Code	Cell Phone No.
Occupation	Employer			Work Phone No.

Referred to Provider by (Please check one box & list) ✈ Dr. _____ ✈ Insurance Plan ✈ Website
✈ Family ✈ Friend ✈ Close to Home/Work ✈ Yellow Pages ✈ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION

Is this client covered by insurance? ☐ Yes ☐ No	Is this an EAP visit? ☐ Yes ☐ No	Total Annual EAPs allowed? _____

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
Email Address:			Cell Phone No.
Occupation	Employer	Employer Address	Work Phone No.

Primary Insurance Provider	Insurance Provider:	× Information Provided

Insured's Name	Birth Date	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ✈ Self ✈ Spouse ✈ Child ✈ Other _____

Name of Secondary Insurance (if any) and applicable)	Insured's Name	Group #	Policy #

Client's Relationship to Insured: ✈ Self ✈ Spouse ✈ Child ✈ Other

MEDICAL INFORMATION

Name of your Primary Physician:	Phone Number:

Current Medical Conditions:

Current Medication(s):

Name:	Dosage	Name:	Dosage
Name:	Dosage	Name:	Dosage
Name:	Dosage	Name:	Dosage

Use the comments section on the reverse side if more room is needed.

OTHER SERVICE PROVIDERS

Current Behavioral Health Provider:	

Behavioral Health Provider(s)

Name:	Reason for Service:	Dates of Service:
Name:	Reason for Service:	Dates of Service:
Name:	Reason for Service:	Dates of Service:

Use the comments section on the reverse side if more room is needed.

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment for each appointment. Therefore…

- ☐ **I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.**
- ☐ **I will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.**
- ☐ **I understand that I have a right to discontinue or refuse treatment at any time. However, I understand that I am responsible for any balance due prior to a decision to stop.**
- ☐ **I hereby authorize the release of necessary medical/mental health information for insurance reimbursement purposes.**
- ☐ **After 30 days of no contact you will be notified of possible discharge from services.**

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Comments:

ReGeneration Therapy and Counseling LLC
Chaplin, CT 06235
Phone (888) 316-5221
www.regenerationtc.com

Consent for Treatment

IMPORTANT INFORMATION AND CLIENT CONSENT: Please sign at the end stating you have fully read and understand the information below.

Counselor: _____

CLIENT/COUNSELOR RELATIONSHIP: You and your Counselor have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional, serving your needs by focusing therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: ReGeneration offers services including individual, family, couples, and group counseling. The Counselor is a skilled and experienced professional Counselor. Effective psychotherapy is founded on mutual understanding and good rapport between client and Counselor. It is our intent to convey the policies and procedures used in this practice, and we can discuss any questions or concerns you might have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, discussions about personal issues can bring to the surface uncomfortable emotions. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. However, these benefits cannot be guaranteed. The Counselor works in cooperation with the client to attain personal goals for counseling and/or psychotherapy.

COUNSELING: ReGeneration provides short-term counseling designed to address the client's goals. The first visit will be an assessment session in which the client and Counselor discuss your concerns, and if the Counselor and client agree that therapeutic needs can be met, a treatment plan is developed. If you choose not to follow the plan of treatment or interventions provided to you by your Counselor, services to you may be terminated.

If at any time you feel that you and your current Counselor are not a good fit, please discuss this matter with your Counselor to determine if transferring to a more suitable service would be appropriate. Assistance will be provided in finding someone who will work more effectively with you to meet your needs.

APPOINTMENTS: Appointments are typically scheduled for 45 or 60 minutes long on a weekly basis. More frequent sessions are available if determined appropriate by your Counselor. If you must cancel or reschedule your appointment, please call the office at least 24 hours in advance, whenever possible.

FEE SCHEDULE: There is a separate document that defines the fee for service.

PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment unless other agreed upon arrangements have been made. If you plan on seeking reimbursement from your insurance plan, full payment is expected at the time of service. A statement can be provided for services rendered.

EMERGENCIES: Please inform the Counselor regarding the nature and urgency of the circumstances if you encounter a personal emergency that requires prompt attention. In this event, they will make every attempt to schedule you as soon as possible or to offer other options. It is not always possible to return a call immediately especially at night or on the weekend or when the Counselor is out of town. However, every effort will be made to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: The Counselor follows all ethical standards prescribed by state and federal law. It is required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Counselor and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Counselor has a duty to disclose, or where, in the Counselor's judgment, it is necessary to warn or disclose; fee disputes between the Counselor and the client; a negligence suit brought by the client against the Counselor; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Counselor when you and the Counselor discuss this matter further. By signing this Consent for Treatment form, you are giving consent to the undersigned Counselor to share confidential information with all persons mandated by law and the insurance carrier responsible for providing your mental health care benefits and payments. You are also releasing and holding harmless the undersigned Counselor from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Counselor believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Counselor to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Counselor to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____

INDEPENDENCE OF OFFICE LOCATIONS: Regeneration Therapy and Counseling LLC (RTC)may manage satellite office locations in established organizations. RTC is a distinct organization operating solely independent of any established organization.

CONSENT TO TREATMENT: By signing this Consent for Treatment form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, ReGeneration Therapy and Counseling will not render services to your child until the Counselor has received and reviewed a copy of the most recent applicable court order.

Please Check if you agree to following statement:

☐ **I hereby authorize the release of necessary medical information for insurance reimbursement purposes**

_____	_____
Signature – Client/Parent	Date
_____	_____
Signature – Spouse/Partner/Care Taker	Date
_____	_____
Counselor	Date

ReGeneration Therapy and Counseling LLC

Fee for Service Agreement

Client Name _____ **Date:** _____

Fees for services provided by Regeneration Therapy and Counseling. We will submit claims to insurance companies as contracted. Direct fee payments will be as noted below unless negotiated otherwise. If you do not have insurance and find the standard fee to be out of reach, we will work with you to determine an "Adjusted Fee" rate that makes counseling accessible.*****

Insurance Fee Ranges: (Dependent upon insurance company) Diagnostic & Evaluation 1st Session: $107.00-$156.57 60 Minutes: $97.90 - $132.09 45 Minutes: $65.64-$92.70 30 Minutes: $44.78 - $67.40

Direct Pay Rates

Session Length	*Licensed Counselor Session Fee*	*Associate Counselor Session Fee*	*Intern Counselor Session Fee*
Intake - Evaluation	$ 160.00	$ 120.00	$ 30.00
60 minutes	$ 135.00	$ 100.00	$ 25.00
45 minutes	$ 95.00	$ 75.00	$ 20.00
30 minutes	$ 70.00	$ 55.00	$ 18.00
Specialty Session	$ _____ Description: _____		
Assessments, Official Reports, Letters	$ 100.00 per hour (Invoiced at 15 min intervals)		

***** Adjusted Fee is based on annual gross income and need using the formula below:

Formula for Adjusted Fee: $ Annual Gross _____ x 1/1000 = $_____

Consideration for difficult circumstance: _____

I agree to pay $ _____ for 60 min $ _____ for 45 min $ _____ for 30 min session

Co-Pay - Insurance : I agree to pay my co-pay of $ _____ per session.

I understand the following: (Please indicate agreement by checking the box)

- ☐ Fee is due at my appointment time unless arranged otherwise
- ☐ Insurance billing is submitted at *contracted rates* unless otherwise indicated on this form
- ☐ Permission is granted to use/store credit card on file if you choose to do so
- ☐ Failure to contact RTC at least 24 hours in advance to cancel an appointment can result in a charge of $50.00

Client Signature: _____ Date: _____

ReGeneration Therapy and Counseling LLC
Chaplin, CT 06235

Consent to Use PHI for Treatment, Payment, and Healthcare Operations

With my consent, ReGeneration Therapy and Counseling LLC (ReGeneration TC) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Please refer to ReGeneration TC's Notice of Privacy Practices for a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices prior to signing this consent. ReGeneration TC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices can be obtained by forwarding a written request to Fritz Maurer @ ReGeneration Therapy and Counseling, 350 Phoenixville Road, Chaplin, CT 06235.

•With my consent, ReGeneration TC may contact my *cell phone* for calling or texting to leave a message or voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care.

•With my consent, ReGeneration TC may *mail* to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential

•With my consent, ReGeneration TC may *e-mail* to me my appointment reminders and patient statements.

I have the right to request that ReGeneration TC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

Preferred Method of Contact: _____

Requested Restrictions: _____

By signing this form, I consent for ReGeneration TC to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ReGeneration TC may decline to provide treatment to me.

Signature of Client or Legal Guardian Date

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Therapist Signature: Date:

_____ _____

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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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Re=Generation Therapy and Counseling.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with ReGeneration, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **There will be no retaliation against you for filing a complaint.**

The effective date of this Notice is September 15, 2013.

ReGeneration Therapy and Counseling
Chaplin, CT 06235
Phone (888) 316-5221
www.regenerationtc.com

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name:_____

DOB: _____

Client Name:_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of "Notice of Privacy Practices." I understand that if I have any questions regarding the Notice or my privacy rights, I can contact ReGeneration Therapy and Counseling LLC directly.

_____
Signature of Client

_____
Signature of Client

_____
Signature or Parent, Guardian or
Personal Representative*

_____
Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt:

_____
Signature of Therapist Date