Reflections Counseling
2955 McKinley Highway, Suite C, South Bend IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

Registration Information

Today's date _____

Sex: Male Female

Client's Last Name | First Name | Middle Initial

Parent/guardian name

Client's Social Security # | Birthdate | Age

Street Address | City | State | Zip Code

Home Phone | Cell Phone | E-mail Address

Where can we leave messages? Home ☐ Cell ☐ E-mail ☐

Employer | Occupation

Name of Primary Care Doctor | Phone # | Fax #

Primary Care Doctor Address | City | State | Zip Code

Insurance Information

In order for us to file bills with your insurance you must complete all of the following information. Your signature and initials are required at the end of this section. We will also need a copy of your insurance card(s).

Insurance Company Name | Insurance ID # | Group#

Policyholder's name | Policyholder's birthdate | Policyholder's social security #

Policyholder's address | City | State | Zip

Policyholder's employer | Client's relationship to Policyholder

Name of EAP (if relevant) | Authorization # | # of Sessions Authorized

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Insurance Information

_____ (initial) I understand the certain information about me can be released to insurance companies in order to process claims.

_____ (initial) I authorize payment of medical benefits to the provider for mental health services delivered

_____ (initial) I understand that co-pays are due at the time of service

_____ (initial) I understand that I am financially responsible for services rendered that are not covered by the above-mentioned insurance company

I hereby give permission to Reflections Counseling to provide me with mental health services within the scope of the provider's license and training.

Client or Parent/Guardian's signature date

History

Have you had counseling before? Yes No

If yes, when? _____

Who was your counselor? _____

Do you see a psychiatrist? Yes No

If yes, what is your psychiatrist's name? _____

Please list any medications you are taking: _____

How would you rate your overall health? 1 2 3 4 5
Poor Neutral Excellent

How often do you drink alcohol? _____ times per month

How many drinks do you typically have in one sitting? _____

Do you use any other drugs (marijuana, cocaine, prescription medications that aren't yours)?

Yes No

If yes, what do you use and how often? _____

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Marital Status: single / married / separated / divorced / widowed / significant other

Please list some of the important people in your life:

Name	Relationship to you

How did you find out about our practice? _____

Emergency Contact Information

Emergency Contact Person Phone # Alternate Phone #

Relationship to Client

What Brings You In

Below are problems that some people face. Please circle those that pertain to you.

Suicidal Thoughts	Cutting/Burning Self	Obsessions
Excessive Worrying	Drug/Alcohol Use	Mood Swings
Nervousness	Work Trouble	Impulse Control
Panic Attacks	Relationship Trouble	Parenting Struggles
Shyness	Trauma	Hallucinations
Stress	Eating Problems	Physical Health Problems
Depression	Sleep Problems	Anger/Irritability
Concentration	Fears	Hyperactivity
Motivation	Finances	Physical/Sexual Abuse

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Financial Policy

We are committed to providing you with the best possible care in the most cost effective way possible. Please review our financial policy below.

We accept cash, checks, and credit card payments; we charge a $25.00 bank charge for returned checks. If you have insurance, we will work with you to help you receive the maximum benefit possible.

Please pay all co-pays, co-insurance, and deductible amounts at the end of each session. If you cannot afford to settle your account in full at the end of a session, we do have payment plans available. We take most insurance and ask that you call the number on the back of your insurance card prior to your appointment to verify benefits and coverage.

For an account that becomes delinquent (overdue 90+ days) we reserve the right to charge a 33% collection-handling fee on the balance to send to a collection agency. At that point, you will be responsible for all costs associated with the collection process to the extent permitted by the law.

If you do not attend a scheduled appointment and do not call your therapist within 24-hours prior to the appointment, we reserve the right to charge a $40.00 no-show fee.

By signing below, you are agreeing to our financial policy. The enforcement of this agreement is governed by the State of Indiana. We reserve the right to change this policy at any time.

Please ask any questions you may have about this document prior to signing.

_____

Printed Name of Client

_____

Signature of Client or Parent/Legal Guardian date

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HIPAA Acknowledgment

I understand that I have specific rights to privacy regarding my protected health information. (Protected health information refers to information that is related to past, present, and future information about your physical and mental health.)

I understand that this information can be used to

- Obtain payment from insurance companies and other third-party payers, including secure electronic billing.
- Conduct, plan, and direct my treatment among healthcare providers who may be involved directly or indirectly in my treatment.
- Perform normal operations such as quality of care assessments and provider certifications.

I received a copy (electronic or paper) of the privacy policy and was given the opportunity to review this policy before signing this acknowledgment.

I understand that Reflections Counseling has the right to make changes the privacy practices. I have the right to contact Reflections Counseling at any time to obtain the most current copy of the privacy policy.

I understand that I may request certain restrictions related to how my protected health information is used or disclosed for treatment or payment. This request must be made to Reflections Counseling in writing. I further understand that Reflections Counseling is not required to comply with my request.

_____

Printed Name of Client

_____

Signature of Client or Parent/Legal Guardian date