Client Registration Form

CLIENT INFORMATION

Client's Name: _____

Preferred Name: _____ Date of Birth: _____

Social Security Number: _____ Male ☐ Female ☐

Street Address: _____

City: _____ State: _____ Zip:_____

Home Phone #:_____ Name listed under? _____

Mobile Phone #:_____ Name listed under? _____

Client lives with: _____ Relationship to Client: _____

If applicable, Client is in legal custody of: _____ Full ☐ Joint ☐

Father's name: _____ Mother's name: _____

Stepfather's name: _____ Stepmother's name: _____

RESPONSIBLE PARTY/GUARANTOR

The Responsible Party/Guarantor for your family's account is the person responsible for paying the bill. This may or may not be the person who holds the health insurance policy. Clients under age of 18 may not be guarantors for their medical bills. In the case of separated or divorced parents, the parent/legal guardian who brings the minor in for treatment is the guarantor for any charges incurred. The only way that this situation may be changed is if the practice is given copies of a court order that states another party is responsible for medical bills.

Responsible Party/Guarantor: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #:_____ Cell #:_____ Work #:_____

Social Security Number: _____ Employed By: _____

HEALTH INSURANCE INFORMATION

PRIMARY: _____ SECONDARY: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Relation to Client: _____ Relation to Client: _____

Member ID Number: _____ Member ID Number: _____

Group Number: _____ Group Number: _____

PLEASE LET US KNOW TODAY if you are using your EAP for your initial visits. Yes ☐ No ☐

If Yes, insurance name & authorization #: _____

HEALTH INSURANCE/BILLING/FINANCIAL POLICY

We are committed to providing you with the best possible care. If your insurance has **coverage for mental health, occupational therapy, physical therapy, and/or speech therapy** we anticipate helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. **You must realize, however, that:**

1. Your insurance is a contract between you and your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. The Therapy Tree, LLC is NOT responsible for keeping up with your insurance company's deductible, co-pays, co-insurance and/or the number of visits authorized by your insurance.
4. Co-payments, Co-Insurance, and Deductibles must be paid at the time of service.
5. If you do not have insurance or if your services are not covered by insurance, payment for service is due at the time of service *unless* payment arrangements have been approved in advance by our staff. We accept cash, checks, MC, VISA, Discover, and Care Credit.

We must emphasize that as Providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our clients, all charges are your responsibility from the date the services are rendered and are to be paid in full within 90 days. We realize that temporary financial problems may arise and we encourage you to contact us promptly for assistance in management of your account.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health, speech, occupational, and physical therapy services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some Clients feel that they need more services after insurance benefits end. At this point, the client will be required to be put on hold or to pay a reduced

out of pocket fee at the time of service unless other arrangement are made in advance of the first non-covered session.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer or cloud. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, and the accompanying Authorization, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

PROFESSIONAL FEES

Counseling - During the initial consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 45-60 minutes. Longer or shorter visits may be scheduled at times.

Initial consultation session is $140
Individual 45 minute session is $140
Individual 60 minute session is $186.66
Family 45-60 minute session is $155
An additional $30/session may be charged depending on complexity

Speech - During the consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 30-60 minutes. Longer or shorter visits may be scheduled at times.

Initial consultation, assessment and evaluation is $360
30 minute session is $100
45 minute session is $150
60 minute session is $200

OT/PT - During the consultation, the client and therapist together will agree on the frequency of future visits, which will usually be 30-60 minutes. Longer or shorter visits may be scheduled at times.

Initial consultation, assessment and evaluation is $360
30 minute session is $90
45 minute session is $135
60 minute session is $180

Other fees:

1. Telephone consultations with you, or on your behalf, may be billed at a rate proportionate to the rate for therapy. Written communications to you or on your behalf will also be billed at a similar rate (e.g. letter preparation or email consultation).

2. The fee for returned checks is $30.00.
3. Any court appearance, or deposition, or the provision of documents for any attorney or for the court will be billed at a rate of $200 per hour, and will include preparation and travel time. Insurance does not cover these services. You may be asked to pay for time reserved in advance or pay a retainer, either of which is necessary before the court appearance or deposition can occur.
4. School IEP meeting attendance is billed at a rate of $75 per hour and will include preparation and travel time. The Therapy Tree does not bill insurance for attendance at IEP meetings.

Payment is due at the time of service. We accept VISA, MasterCard, Discover, check and cash. If you have and are using insurance coverage, you MUST call to verify coverage, obtain pre-authorization (if required) and verify your co-pay amount and deductible remaining before the first visit, or you will be asked to pay full fee for the first visit.

Fees are subject to change at any time with or without prior notice.

CANCELLATION POLICY

As therapists, we work as service providers. Therefore, our only commodity is our time (and expertise). A scheduled appointment is like a contract: the client has hired us to provide our undivided attention during a specified period of time. When someone fails to appear for a scheduled appointment, we are not able to fill in that time with another client. When appointments are cancelled less than 24 hours before the appointment, we likewise may not be able to fill the time. Therapists needing to cancel their scheduled appointments with families will also provide 24 hours' notice prior to appointment when possible.

The Therapy Tree may charge a cancellation fee of $30 per missed session, and has the option of terminating services following three missed appointments. We cannot bill your insurance company for a missed appointment.

Illness - If you or your child has any of the following symptoms, treatment should be canceled. This also applies if any members of the household show these symptoms when the therapist provides treatment in the home.

- Fever of 100 degrees or higher, diarrhea, or vomiting within 24 hours of treatment time.
- Serious sneezing or coughing, especially with mucous present.
- Watering/mattering eyes, discharge from ears.
- Runny nose when discharge is NOT clear.
- When child or member of household is exposed to serious childhood illnesses like chicken pox, measles, hand/foot/mouth disease, RSV, etc.
- Unusual spots, rashes, or bruises not associated with injury.
- Sore throat or difficulty swallowing.
- Unusual behavior, child does not feel well enough to participate in normal activities.

Weather – In case of inclement weather, please call the office main line at 847-265-7300. A message will be recorded announcing if clinic is closed due to weather. Typically, if Lake Villa/Lindenhurst School District #41 is closed due to weather, then The Therapy Tree may also close. Whenever the clinic remains open, please call to cancel your appointment if weather conditions prevent your attendance.

CONTACTING US

Our office hours are 8:30 a.m. to 8:00 p.m., Monday through Friday and 8:00 a.m. to 4:00 p.m. on Saturday. We make every attempt to answer every call; however, you may at times have to leave a message. Messages are checked often and calls returned promptly. Late afternoon or evening messages left may be answered the morning of the next business day. Please do not ever leave an urgent message on voicemail. It is best to contact your therapy provider directly for urgent messages, cancellations and scheduling questions.

ABOUT COUNSELING THERAPY

Individuals consult with Mental Health Professionals (MHPs) for a variety of reasons. We will make every effort to respect your individual needs and goals in treatment. The therapy process involves a working partnership between you and your MHP. Our work may include a variety of activities, and for optimum outcomes to occur, your active participation is essential. We will attempt to help you achieve your goals, but we cannot guarantee that the outcome will be what you now seek. In addition, change is often accompanied by feeling states that can be distressing. You may experience moments of frustration, anxiety, feelings of depression, self-doubt, and confusion. While we are trained, licensed and experienced MHPs, we cannot guarantee change nor can we promise that all problems will be resolved.

For counseling therapy with children under the age of 14, it is our policy to request an agreement in which parents (or guardians) consent to give up access to the child's records. If a diagnostic evaluation or assessment is requested, we will discuss findings, results, and treatment plans with you. Most of the minors we see are brought voluntarily by their parents and come with parental knowledge. In such circumstances, parents are often understandably curious about the treatment of their children. It is our position, however, that young people need to develop trust in their therapist and need some degree of security and privacy. Therefore, we specifically request that you limit your inquiry about the details of their therapy. We need you to know that we will, indeed, bring to your attention matters that we believe are important for you to know, and we request that you trust our judgment about this important issue. We also hope that you will refrain from asking your child what has transpired in therapy or diagnostic sessions.

If your child is 14 or over, we cannot discuss anything about evaluation or treatment with you without the written Authorization from your child.

CONFIDENTIALITY

The law protects the privacy of all communications between a Client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health, therapy, and mental health professionals about a case. During a consultation, we avoid revealing the identity of our Client. Nonetheless, the other professionals are still legally bound to keep the information confidential. Unless you object, we may not tell you about these consultations, unless we feel that it is important to our work together.

- You should be aware that we practice with other therapists and mental health professionals, and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and

quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.

- If a Client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or authorization.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-Client privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a Client files a complaint or lawsuit against one of us, we may disclose relevant information regarding that Client in order to defend ourselves.

- If a Client files a worker's compensation claim, we may disclose information relevant to that claim to the Client's employer or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a Client's treatment. These situations are unusual in our practice.

- If we know or suspect that a Client under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Illinois Department of Client and Family Services (DCFS). Once such a report is filed, we may be required to provide additional information.

- If we know or suspect that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually DCFS. Once such a report is filed, we may be required to provide additional information.

- If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), we may disclose that information, but only to those reasonably able to prevent or lessen the threat.

If one of these situations arises, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, test results, and any reports that have been sent to anyone, including reports to your insurance carrier. If you provide us with an appropriate written request, you have the right to examine and/or receive a copy of your records, expect in unusual circumstances that involve danger to you or others. In those situations, you have the right to have your record sent to another provider. In most situations, we are allowed to charge a copying fee of $25. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we may also keep a set of Therapy Notes. These notes are for our own use, and are designed to assist us in providing you with the best treatment. While the contents of therapy notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. These Therapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Therapy Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Therapy Notes unless we determine that such disclosure would be reasonably likely to be detrimental to your health. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We will be happy to discuss any of these rights with you.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ALL TERMS.

_____

Printed Name of Client/Guardian

_____ _____

Client/Guardian Signature Date Signed

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"Growing Together in Mind and Body"
www.thetherapytree.org

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

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