PINNACLE Family Counseling

REGISTRATION INFORMATION

How did you hear about us?

CLIENT INFORMATION

CLIENT FULL NAME	DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE ☐ TRANS

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER	EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY ☐ OTHER	STUDENT STATUS ☐ FULL TIME ☐ PART TIME

ADDRESS	CITY/STATE/ZIP

HOME PHONE	CELL PHONE	WORK PHONE	INDICATE BEST # TO LEAVE MSG ☐ HOME ☐ CELL ☐ WORK

EMAIL ADDRESS	OK TO DISCUSS SCHEDULING VIA EMAIL? ☐ YES ☐ NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐ YES ☐ NO

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP TO CLIENT

INSURANCE

INSURANCE PLAN:	POLICY NUMBER:	POLICY HOLDER NAME & DOB

POLICY HOLDER RELATIONSHIP TO PATIENT

PHONE NUMBER ON BACK OF CARD:	COPAY	DEDUCTIBLE MET?	Please see rates if deductible not met www.pinnaclefamilycounseling.com

RESPONSIBLE PARTY (IF DIFFERENT THAN CLIENT)

BILLING FULL NAME	RELATION TO CLIENT ☐ LEGAL GUARDIAN ☐ SPOUSE ☐ PARENT OF 18+ DEPENDENT ☐ OTHER

BILLING ADDRESS	CITY/STATE/ZIP

BILLING PHONE	LEAVE MSG? ☐ YES ☐ NO	EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐ YES ☐ NO

ALL BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

**** Policies with a DEDUCTIBLE or Out of Network Insurance Coverage REQUIRE A CREDIT CARD ON FILE***

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover	EXP DATE	CVV CODE

CARD NUMBER

CARD HOLDER NAME

I hereby give consent to charge my credit card below for any outstanding balances (you will be notified prior to your card being charged)

CARD HOLDER SIGNATURE	DATE

PRIVATE PAY Payment due IN FULL at the time of service.

SERVICE DESCRIPTION (EXAMPLE: INTAKE)	RATE/UNIT (EXAMPLE: $200/45-50 MIN) $ /	SERVICE DESCRIPTION	RATE/UNIT $ /

IMPORTANT POLICIES

CLIENT FULL NAME	DATE OF BIRTH

if client is a minor, please print name of parent/guardian(s) signing on behalf of the client:

PRINT FULL NAME	RELATIONSHIP TO CLIENT
PRINT FULL NAME	RELATIONSHIP TO CLIENT

MISSED APPOINTMENTS

I am financially responsible for my attendance at all scheduled appointments, unless cancelled with at least 24 hour notice. Minimum charges of $50 will be applied to my account for a late cancel and $85 for a no-show.

ACCOUNT RESPONSIBILITY

I am responsible for payment for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, Pinnacle Family Counseling & Consultation reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names Pinnacle Family Counseling & Consultation as a creditor in any bankruptcy filing.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

RECORDS RELEASE – Primary Care Physician

- ☐ I do not have a Primary Care Physician
- ☐ I do not want information to be released to my Primary Care Physician at this time
- ☐ I will allow my information to be released to my Primary Care Physician. If so, please complete the included Release of Information form.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

I am consenting to treatment and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA).

My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all of the terms and conditions of the Counseling Policies. If I have questions, the information has been explained and/or summarized for me.

SIGNATURE(S) (CLIENT OR LEGAL GUARDIAN)	DATE
SIGNATURE(S) (LEGAL GUARDIAN)	DATE

PINNACLE
Family Counseling

PRIMARY CARE PROVIDER NOTIFICATION OF CLINICAL SERVICES AND CONSENT FOR THE RELEASE OF INFORMATION

Continuity and coordination between physical and mental health is an important aspect in the delivery of quality health care, as mental and physical disorders can interact to affect an individual's health.

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	INTAKE DATE

PRIMARY CARE PROVIDER/CLINIC

PHONE	FAX

ADDRESS CITY/STATE/ZIP

MENTAL HEALTH PROVIDER INFORMATION

Dear Primary Care Provider,
I am sending this form to notify you that I am currently seeing your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience.
Sincerely,

MAILING ADDRESS:

67 S Bedford St Suite 400,
Burlington, MA 01803

CLINICAL INFORMATION

REASON FOR REFERRAL OR CARE COORDINATION

DIAGNOSIS	MEDICATIONS

TREATMENT PLAN(S) OR RECOMMENDATIONS

CONSENT AND RELEASE

I authorize the exchange of information regarding my clinical care needed to coordinate treatment with my primary care physician. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 1 year after last contact and I may cancel it in writing at any time.

SIGNATURE(S)	DATE
SIGNATURE(S)	DATE