Registration Form

Reimann Counseling Clinic, PLLC

DX Code ______________________

Date ______________________ Therapist ______________________

Patient Information

Patient Name (Print)______________________________ **Date of Birth** ______________________
Last Name First Name Initial

Street Address ______________________________ Home Phone ______________________

City ______________________ State ________ ZIP ______________ Cell Phone ______________________

Soc. Sec. # ______________________ Work Phone ______________________

Sex: ☐ Female ☐ Male Age ________ Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Employer ______________________ Occupation ______________________

Referred by ______________________ May we acknowledge this referral? ______________________

Primary Insurance

Primary Insurance Company ______________________________ Phone ______________________

Ins Claims Address ______________________ City ______________ State ________ Zip ______________

Policy / Member ID ______________________ Group/Account # ______________________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ______________________________ **Date of Birth** ______________________
Last name First Name Initial

Address ______________________ City ______________ State ______ Zip ______________ Relationship ____________

Soc. Sec# ______________________ Employer ______________________

Secondary Insurance

Secondary Insurance Company ______________________________ Phone ______________________

Ins Claims Address ______________________ City ______________ State ________ Zip ______________

Policy / Member ID ______________________ Group/Account # ______________________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ______________________________ **Date of Birth** ______________________
Last name First Name Initial

Address ______________________ City ______________ State ______ Zip ______________ Relationship ____________

Soc. Sec# ______________________ Employer ______________________

Responsible Party

(Where should the patient's portion of the bill be sent, if not to the patient?)

Name ______________________________ Relationship ______________________

Address ______________________________ Phone ______________________

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________ ______________________
Responsible Party Signature Relationship Date

Billing Information and Policy

Our billing policy for services, which are the client's responsibility, is as follows:

Please initial each item:

______ All co-pay, co-insurance, sliding fee scale, payment plan, and deductible amounts are due on the date of service. If client payments are not made on the date of service, or if arrangements for an alternate payment plan have not been made, charges will be submitted to the client's credit or debit card on file in our office.

______ Clients will not receive a statement for services that are the responsibility of their insurance company. Clients will not receive a statement if their balance has been paid in full on each date of service and their account is current.

______ Any psychological services that are not eligible for coverage through a client's insurance plan or EAP become the client's responsibility. If not paid on the date of service, these charges will be submitted to the credit card on file either on the date of service or on the date we receive notice that services have been denied.

_______ A late cancel fee will be charged to the credit or debit card on file for clients with private insurance coverage, a payment plan, or a sliding fee scale, including cash clients. This charge is submitted on the date of service only if clients miss an appointment without giving a 24-hour notice to cancel or do not show up to a scheduled appointment without 24-hour notice.

_______ By signing, you agree that: I understand that if I default on any payment obligations as called for in this agreement, Reimann Counseling Clinic will have the right to forward my information to collections. I understand and give my consent for Reimann Counseling Clinic to forward my information to collections should I default on this agreement and fail to pay my Balance Due.

Credit Card Information

We require all clients to keep a credit card on file in accordance with the above billing policy.

Name on Credit/Debit Card:

____

Address of Card Holder:

____

Credit Card Type: Visa: _____ MasterCard: _____ Discover: _____ American Express: _____

Card #: ___________________________________ Exp Date: ______________ 3 Digit CVV # on Back of Card: _______

I acknowledge I have been informed and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Reimann Counseling Clinic may bill the credit card on file for any payments that are my responsibility and have not been paid on the date of service. I hereby consent to Reimann Counseling Clinic utilizing my credit card information for any outstanding balance.

____

Signature of Credit Card Holder, Authorizing Payment

Medical Care

Clinic Doctor's name: ____ Phone: ______________________________

Address: ____

Are you on any medications? If so, please indicate name and dosage: ____

If you enter treatment with us for psychological problems, may I tell your medical doctor so that he or she can be fully informed, and we can coordinate your treatment?

Circle: YES or NO

Emergency Information

If an emergency arises and we cannot reach you directly or need to reach someone close to you, whom should we call?

Name: ______________________________________ Phone: _________________________
Relationship: ________________

Clinic Information and Client Consent Policies

Overview of Therapy

Therapy varies depending on the therapist, the client, and the client's particular situations and goals. Your therapist may use many different methods to deal with your particular situations and goals. In order for therapy to have the best outcome, you will likely have to invest energy into the process and work actively on things we talk about during and between our sessions.

Therapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety, or frustration when discussing aspects of your life or relationships. Research shows psychotherapy to have benefits that can include better relations, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, it is impossible to predict or guarantee what you will experience.

Your first few sessions will involve an evaluation of your situation and needs. We will also discuss your goals. During this time, you and your therapist together will decide if your therapist is the best person to provide you with therapeutic services. Therapy can involve a significant investment of time, energy, and money so it is important you select a therapist you are comfortable working with. If at any time you have questions about any aspect of your work with your therapist, please discuss them with your therapist. If you decide you do not want to continue in therapy, please inform your therapist. If you want help finding another therapist or other appropriate resources, we will happily assist you in doing so.

Crisis Response and Contacting Your Therapist

Your therapist is often not immediately available by phone because we do not answer the phone when in session with clients. Feel free to leave a voicemail and your therapist will get back to you within the next business day (Monday through Friday). We will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours Monday through Friday). If you are difficult to reach, please let us know in advance. When your therapist will be unavailable for an extended time, you will be provided with a backup therapist to contact if necessary.

Outpatient mental health services are consultative in nature; we are not equipped to handle emergencies. Please call the Crisis Connection 612-379-6363, Community Outreach for Psychiatric Emergencies (COPE) 612-596-1223, 911 or go to the nearest hospital emergency room if you are in crisis.

Financial Responsibility

Most health insurance plans include behavioral health coverage; however, the exact coverage varies widely depending on the health insurance plans. Clients are responsible for services received that are not covered by insurance; therefore, we strongly recommend that you call your insurance company to verify coverage. When you call your insurance company, ask to verify your coverage for outpatient mental health. It is also your responsibility to keep us updated with any changes in your benefit plan and/or insurance coverage.

Cancellation Policy

Please give a 24-hour notice if you are not able to make an appointment. If you do not give a 24-hour notice, you will be charged **$100, which is not billable to insurance companies. Please phone us with cancellations as soon as possible to avoid late cancellation fees and out of respect for** others who may need that appointment time.

Cases Involving the Legal System

Our services are not to be utilized for testimony, custody disputes, disability or any other form of court evaluations. We are happy to refer you to other providers in the area who provide these services should you require any court evaluation or testimony. Should we be subpoenaed or mandated by the courts to testify, you will be required to pay all fees associated with the writing of case summaries and/or other reports, consultation with mental health professionals, review of other records, and any other preparation. The client will also need to pay for other fees incurred including travel time, meals, parking and all other costs associated with the court time. Therapist testimony will require the client be billed directly, as insurance will not cover these charges. All fees must be paid prior to the date of testimony. Court appearances are significantly more expensive due to the complexity and difficulty of being involved in such matter.

Rates

Billing Code	Services	Length of Visit	Fee for Service
90791	Intake	45-50 minutes	$250
90837	Psychotherapy 60 minutes	53 minutes	$180
90847/90846	Family/Couple Therapy	45-50 minutes	$200
Billed to Client	Late Cancelation/No Show	N/A	$100

Reimann Counseling Clinic reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. My signature below indicates I am consenting to treatment at Reimann Counseling Clinic, and have received and understand the contents of the clinic's counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.

____ ____________________

Signature (Client of Legal Guardian if client is under 18) Date

My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorizes Reimann Counseling Clinic to pursue any outstanding balance due to them should I not follow the clinic policy.

____ ____________________

Signature (Client of Legal Guardian if client is under 18) Date

EAP

EAPs must be given on the date of service or before service begins to be eligible to use. We do not accept EAPs given on a later date to back track payments. This is due to creating an extensive back log in accounts billing systems. It leaded to charges taking too long to be processed and usually coverage gets denied. When an EAP is denied, the bill becomes the responsibility of the patient.

When an EAP is given, we need the physical documentation to scan and have a copy on file. This helps prevents any mix up in the authorization numbers on the EAP form. We do not accept EAPs without the proper documentation.

If you have an EAP and forget to give it to us it will be used on upcoming appointments once the paperwork is brought in. The EAP starts once the paperwork is brought in and we are notified. There is no back tracking.

Signature________________________________

Date______________________________

Reimann Counseling Clinic
Informed Consent to Treatment

Client:______________________________________Date of Birth: ________________

1. I authorize Reimann Counseling Clinic to provide mental health services to me/my child. I understand that services may include any of the following: assessment, individual, group and family therapy. Therapy and support services will be provided by or under the direction of mental health professionals.

2. I understand that the goals of treatment will address that the goals of treatment will address the mental health issues confronting me/my child. I understand that services I/my child will be receiving from Reimann Counseling Clinic will be directed toward addressing specific goals aimed at improving my/my child's sense of wellness and health.

3. The nature and purpose of treatment, possible alternative methods of treatment, the risks involved, and the possibility of complications have been explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

4. I consent to the performance of therapeutic and support procedures as described in the treatment plan. I understand that any major changes will be explained to me/my child and that I may decline further treatment or negotiate for alternative procedures at that time. THIS AUTHORIZATION FOR SERVICES IS IN EFFECT FOR ONE YEAR.

5. I understand that all information will be used only in accordance with the Minnesota Data Privacy Act for mental health centers and will not be permitted to be distributed among unauthorized persons.

6. My/my child's Client Rights have been explained to me and I have received a copy of these Rights.

7. I have received a copy of Reimann Counseling Clinic Notice of Privacy Practice.

8. I understand that the first 1-4 sessions will be for assessing treatment needs, at the end of which an integrated treatment plan will be developed.

____

Signature of Client /Parent Guardian Signature Date

____

Signature of Therapist Date

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