Alphabet Shuffle, LLC

CLIENT REGISTRATION FORM

(Please Print Clearly)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Social Security Number_____

Home Address_____
Street

_____ _____ _____ _____
City *State* *Zip* E-mail Address

Home Phone _____ Work Phone _____ Cell Phone _____

Gender:	**Marital Status:**	**Are You:**
□ Male □ Female	□ Single □ Married □ Divorced □ Widowed	□ Hispanic/Latino □ Not Hispanic/Latino
Race: □ White □ Black / African-American □ Asian □ American Indian/Alaskan Native □ Native Hawaiian □ Pacific Islander □ More Than One Race □ Other: _____	**Client's Driver's License Number:** _____	**Driver's License State:** _____

Employment Information:

Employer Name _____

Employer City_____ State_____

If Minor: Please List The Name Of Mom And Dad Or Legal Guardian(s):

Mom or Legal Guardian_____ Phone Number_____

Dad or Legal Guardian_____ Phone Number_____

Responsible Person: (If Different From Client)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Social Security Number_____

Home Phone _____ Cell Phone _____

Address_____
Street

_____ _____ _____
City *State* *Zip*

Driver's License Number_____ Driver's License State_____

Relationship to Client_____

Person To Contact In Case Of Emergency:

Name _____ Telephone Number _____

Relationship to Client _____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance _____

Member ID Number _____ Group # _____

Name of Subscriber _____ Employer _____

Date of Birth _____ Social Security Number_____

Relationship to Client: □ Self □ Parent □ Spouse □ Partner □ Other

SECONDARY INSURANCE

Name of Insurance _____

Member ID Number _____ Group # _____

Name of Subscriber _____ Employer _____

Date of Birth _____ Social Security Number_____

Relationship to Client: □ Self □ Parent □ Spouse □ Partner □ Other

How did you hear about our agency center? _____

Briefly describe the reasons you are here today_____

_____

_____

Have you ever had counseling before? □ Yes □ No If yes, where? _____

Authorization and Consent

I, the undersigned, hereby state that have voluntarily consented to out-patient mental health treatment, or am giving my consent for a minor or person who is under my legal guardianship for out-patient mental health treatment at Alphabet Shuffle, LLC. I am aware that this out-patient mental health will be provided by a counselor or intern in collaboration with his/her supervisor. I understand that the out-patient therapy may be discontinued at any time by either party.

Confidentiality. The confidentiality of client's files maintained by Alphabet Shuffle, LLC is protected by federal and state law and regulations. Generally, your files will not be disclosed to a person outside Alphabet Shuffle, LLC unless:

- The client/guarantor consents in writing to the disclosure.
- The client verbally consents to disclose information to family members directly involved in your treatment.
- The disclosure is mandated by a court order, subpoena, or administrative order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is made to Public Health Agencies to control disease, injury, or disability.
- The disclosure is made to qualified personnel for research, audit, or program evaluation.

Violation of federal and state laws and regulations by anyone contracted to work for Alphabet Shuffle, LLC is a crime. Suspected violations can be reported to appropriate authorities. Professional misconduct by a health care professional must be reported to the proper authorities by other health care professionals. In such a case, related client files may be released to those authorities to substantiate disciplinary concerns.

Without Authorization: It is further stated that any client admitting to harming themselves or others do not have protection of confidentiality within federal and state laws and regulations. Any suspected self-harm or abuse to self or others will be reported to the proper authorities.

Death: In the event of your death, your spouse or the parents of a child have the right to access your files. Parents or legal guardians of non-emancipated minor patients have the right to access the patient's files.

Specialized Government Functions: Alphabet Shuffle, LLC may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials of national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your out-patient mental health information based on your consent, mandatory disclosure laws and the need to prevent serious harm.

Cancellation/No Show Policy: I understand the time allotted for my counseling session has been reserved for me. Alphabet Shuffle, LLC requires all clients to give a 24 hour notice for cancellations. If you do not give notice, or are a no-show/no-call, you will be billed at the rate of $30.00. You will not be able to schedule another appointment until all fees are paid in full.

Recipient Rights: I have received the Recipient's Rights notification and have read and understand its content. I understand as a recipient of services, I may get more information from Alphabet Shuffle, LLC's Recipient Rights Advisor.

I have reviewed this consent and have had ample time to discuss any concerns with my counselor/worker at Alphabet Shuffle, LLC. My signature below verifies that I have been given a copy of my voluntary consent to treatment at Alphabet Shuffle, LLC, and will allow a copy of this authorization to be used in place of the original.

Signature of the Client/Legal Guardian _____

Relationship to Client _____ Date _____

Authorized Staff Signature _____ Date_____

Insurance And Payment Information

Alphabet Shuffle, LLC receives payment for patient care from insurance companies, Medicare, and/or other third party programs.

1. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to Alphabet Shuffle, LLC.
2. I acknowledge that I am responsible to notify Alphabet Shuffle, LLC about new insurance cards, carriers, or dropped coverage.
3. I acknowledge that I am also responsible for other professional services rendered by my counselor (letters and/or reports necessary for lawyers, doctors, school personnel, testifying in court, consultation with attorneys, etc.).
4. I agree to let Alphabet Shuffle, LLC submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care.
5. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.
6. If I am a self-pay client, the fee is $30.00 per hour session.

Special Note About Mental Health Benefits:

If you are using your health insurance benefits to pay for mental health treatment, your insurance company will need some information from Alphabet Shuffle, LLC. If you are going to receive mental health care as an outpatient, your insurance company may have limits on the number of visits for which it agrees to pay. We ask you to remain informed of your specific plan's mental health benefits. The information which insurance companies require from us for initial sessions is limited in its scope (i.e. diagnosis, type of treatment). However, if your treatment is to go beyond those initial sessions authorized by your insurance company, then additional information will need to be given to your insurer. This additional information allows your insurer to determine if the treatment is medically necessary.

Signature of the Client/Legal Guardian _____

Relationship to Client _____ Date _____

Authorized Staff Signature _____ Date_____

09/14 Created By: TB