

Integrative Counseling, LLC
REGISTRATION FORM

Client Name: _____ Date: _____

Address: _____

Date of Birth: _____ SSN: _____ Email: _____

Phones*: Home: _____ Work: _____ Mobile: _____
**indicate primary contact*

Race: White Black Asian Alaskan American Indian Other: _____

Ethnicity: Puerto Rican Mexican Cuban Other Hispanic Not Hispanic

Mother's/Guardian Name: _____

Father's/Guardian Name: _____

Do you live with her? () Yes () No

Do you live with him? () Yes () No

If no, Address: _____

If no, Address: _____

Phone: _____ SSN: _____

Phone: _____ SSN: _____

Email: _____

Email: _____

Emergency Contact: _____

Relationship to client: _____

Address: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Referral Source: _____

Phone Number: _____

Agency: _____

Fax Number: _____

May we contact your Referral Source? () yes () no

If yes, please be sure to complete a **Release of Information**

Probation Officer/Monitor: : _____

Phone Number: _____

Agency: _____

Fax Number: _____

May we contact your P.O/Monitor? () yes () no

If yes, please be sure to complete a **Release of Information**

Lawyer: _____

Phone Number: _____

Agency: _____

Fax Number: _____

May we contact your Lawyer? () yes () no

If yes, please be sure to complete a **Release of Information**

Administrative use only

Treatment Recommendations

() Group Counseling () Individual Counseling () Family Counseling () _____

() Referred to: _____

Counselor: _____

Group Days: M T W Th F S Su Time: _____

Michigan Alcohol Screening Test

Client Name: _____

Score: _____

	Yes	No
1. Do you feel you are a normal drinker?		
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?		
3. Does your spouse or do your parents ever worry or complain about your drinking?		
4. Can you stop drinking without a struggle after one or two drinks?		
5. Do you ever feel bad about your drinking?		
6. Do your friends or relatives think that you are a normal drinker?		
7. Are you always able to stop drinking when you want to?		
8. Have you ever attended a meeting of Alcoholics Anonymous?		
9. Have you gotten into fights while drinking?		
10. Has drinking ever created problems between you and your spouse?		
11. Has your spouse or other family member ever gone to anyone for help about your drinking		
12. Have you ever lost friends or girlfriends/boyfriends because of your drinking?		
13. Have you ever gotten into trouble at work because of drinking?		
14. Have you ever lost a job because of drinking?		
15. Have you neglected your obligations, your family or your work for 2 or more days in a row because of drinking?		
16. Do you ever drink before noon?		
17. Have you ever been told you have liver trouble or cirrhosis?		
18. Have you ever had Delirium Tremens (DTs), severe shakes, heard voices, or seen things that weren't there after heavy drinking?		
19. Have you ever gone to anyone for help about your drinking?		
20. Have you ever been in a hospital because of your drinking?		
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?		
22. Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergy for help with an emotional problem in which drinking had played a part?		
23. Have you ever been arrested, even for a few hours, because of drunk behavior?		
24. Have you ever been arrested for drunk driving or driving after drinking?		

Integrative Counseling, LLC
Release of Information

I, _____ hereby authorize Integrative Counseling, LLC

to exchange information with: _____
Name of Program, Agency, or Individual

Phone

Fax

The following information may be exchanged:

- _____ Full client record
- _____ Progress and attendance reports
- _____ Admission and discharge diagnosis and recommendations
- _____ Reason for termination of treatment and discharge summary
- _____ Urinalysis/Breathalyzer results
- _____ Immunization and physical records
- _____ Other _____

The above information will be exchanged for the following reason(s):

- _____ To coordinate treatment
- _____ As a condition of probation, parole, or adjudication
- _____ As required by my employer or EAP
- _____ To assist my attorney
- _____ Other _____

This consent will expire one year from the date of signature unless otherwise noted

I understand that my records are protected under Federal Confidentiality 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 the information has already been disclosed in reliance with this consent.

Prohibition of Re-disclosure: This information has been disclosed to you from records protected under Federal Law. Federal Regulations (42CFR Part II) prohibit you from making further disclosures of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

Integrative Counseling, LLC Fee Schedule and Policies

Intake and Assessment	\$150	Individual or Family Therapy	\$95
Group Therapy or Education	\$40	Medication Authorization	\$20
2hr DWI Education	\$80	Written Report	\$50
2hr Adolescent Education	\$100	Urine Screen – THC or Panel	\$35
Family Group/Parent Ed	\$40	Psychiatric Report (per hour)	\$100
Weekend Alcohol Ed	\$395	Letters/Forms	\$25
Psychiatric Interview	\$275	Bounced Check Fee	\$25
Medication Management	\$110	Disability/Workers Comp Reports	\$300
		Crisis Session	\$45

Appointments

If you need to cancel an appointment for any reason, please do so 24 hours before the appointment time. ***It is office policy to charge full fee for missed appointments not canceled 24 hours prior.*** This includes groups – unless prior arrangements are made, you will be expected at the next scheduled group meeting. Insurance does not cover missed appointment charges; they are the responsibility of the client or guardian.

Fees and Payment

Payment will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Integrative Counseling does not accept insurance payments. Statements are provided upon request.

Failure to Pay

The client agrees that failure to pay within ten business days of the service date may, at the option of Integrative Counseling, be construed as a discharge of services by the client. The client further agrees that in the event that legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action. ***Clients sent to collections will be charged the amount owed plus 40% for collection fees.*** The client agrees that information pertinent to the collection of any amount due be released to a third party collection agency or attorney. The client further agrees and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

Court Appearances

Integrative Counseling charges \$200 per hour, with a minimum of \$1,600 per day, for any court appearance whether requested or summonsed. Clients will be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. In the case of minors, the signing parent is responsible for this fee unless otherwise arranged with the non-signing parent. A deposit of \$1,600 is due 10 days prior to any court appearance. If a court appearance is canceled or rescheduled, Integrative Counseling staff must be given ten business days notice. If ten business days notice is not given, then Integrative Counseling may still charge up to \$1600 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

Understanding of Separate Practices

The client recognizes and understands that Integrative Counseling, LLC and Congruent Counseling Services, LLC are separate practices, and as such will require the opening of a new/separate client chart. The client understands that any insurance benefits utilized with Congruent Counseling Services cannot be utilized with Integrative Counseling. Integrative Counseling accepts no third party payers of any kind and has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment. Your signature below indicates understanding of the fees and policies as delineated above.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

Integrative Counseling, LLC

Phone and Teletherapy Policies

Telephone and Internet Session – Teletherapy or Telepsychiatry

Modern life can make it difficult to connect with a therapist or doctor on a regular basis. Traveling, kids, busy work schedules, or going off to college can make it difficult to make the changes you need to make. In order to meet the needs of busy people, we can regularly schedule phone or Internet (Skype) counseling. This way you can work on your goals from anyplace. Teletherapy and telepsychiatry are not covered by insurance and are therefore billed at our standard rates. Clients regularly seen in the office for sessions under insurance can schedule teletherapy/telepsychiatry appointments to bridge some gap with the understanding these sessions will not be billed to insurance. Teletherapy and telepsychiatry clients will be billed via credit card at the time of service. Credit cards must be kept on file with Integrative Counseling. Clients may choose to receive 10% discount by prepaying for a block of ten sessions. Initial sessions must be done in person and are not billable to insurance if telephone or teletherapy/telepsychiatry sessions are the primary mode of treatment.

Missed Appointment Sessions

As noted on the Fee Schedule and Policy page, missed appointments are charged for sessions not canceled 24 hours in advance. We must charge for these missed appointments because we have reserved the time for you and cannot fill your appointment with another client if we have less than 24 hours to do so. This can be very expensive as insurance does not cover missed appointments. However, we understand sometimes life gets in the way. In order to help stay on track in counseling, and to save the full missed appointment fee, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of \$50, far less than the full missed appointment charge. This session will allow you to stay focused on your treatment and schedule your next session at a better time. The missed appointment phone option may only be used once in a 30-day period. Second missed appointments will be charged at the full rate.

Therapist and Counselor Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our counselors and therapists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office. Your counselor or therapist has provided you with personal contact information to help you address your needs. If you would like to talk with your therapist, and cannot wait until the next appointment, please be respectful of their time. In cases where you need the help, we want to help. Please note calls, texts, or emails over five minutes will be charged as crisis session at a rate of \$45. Crisis sessions are not billable to insurance and are the responsibility of the client or parent.

Psychiatrist Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our psychiatrists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office. If you are calling with a therapy or mental health concern, please call your individual therapist. Your psychiatrist has provided you with personal contact information to help you address your needs. If you would like to talk with your psychiatrist regarding medication issues, and cannot wait to schedule an appointment, please be respectful of their time. Calls, texts, or emails to clarify or change medication(s) within seven days of your last appointment are acceptable. Medication calls outside this seven day window will be charged as a Crisis Session at a rate of \$45. Crisis Sessions are not billable to insurance and are the responsibility of the client or parent.

Medication Changes or Refills Between Appointments

We understand it can be difficult to keep track of medications and you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at \$35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. If you know you are unable to make an appointment for an extended period of time you may choose to schedule a Telepsychiatry appointment as described above.

Telephone, Internet, and email communication carry an inherent risk to privacy. By signing below, I indicate recognition of these risks. I have reviewed and understand these options and I have received a copy of the Phone and Teletherapy Policies.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

Integrative Counseling, LLC
Credit Card Recurring Payment Authorization Form

As a courtesy to you, we can now schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started. Once a month, with this authorization, we will charge the balance due on your account to the credit card you list on file.

You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged once each billing period for the total amount due for that period. The charge will appear on your credit card statement.

Please complete the information below:

I, _____, authorize Congruent Counseling Services, LLC to charge the credit card indicated below once between the 15th and 20th of each month for payment of any balance due for _____.
(name of client or clients)

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Email: _____

Account Type: Visa MasterCard Amex Discover
*Is this for a(n): HSA FSA Other Consumer Spending Account
***For all consumer spending accounts, be advised that if the card cannot be processed, you will be billed and should seek reimbursement from them directly.**

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

CLIENT/GUARDIAN SIGNATURE

DATE

Integrative Counseling, LLC
Client Bill of Rights and Confidentiality of Client Records

Client Bill of Rights

Each Client has the right to:

1. Be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. To refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.

Confidentiality of Client Records

The Federal Law and Regulations protects the confidentiality of patient records maintained by this program. Generally the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1. The patient consents in writing;
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

I have reviewed and understand these rights and I have received a copy of the Expectations and Rules and Grievance Procedures.

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

Integrative Counseling, LLC
Client Bill of Rights

Client Copy

Client Bill of Rights

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The Federal Law and Regulations Protect the confidentiality of alcohol and drug abuse patient records maintained by this program. Generally the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

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Integrative Counseling, LLC
Expectations and Rules

Client Copy

Counselor: Mark Donovan Gina Rassa Katie Collier Lisa Cohen Aaron Brager
Other: _____

Group Days: M T W Th F Group Time: _____

Client Expectations and Rules

1. A client who makes a threat or becomes violent will be discharged.
2. A client who brings a weapon will be discharged.
3. A client who becomes verbally abusive will be discharged.
4. All state, county and federal laws will be observed. Violators will be turned in to the appropriate authorities. (Confidentiality – 42 CFR, part II will be observed.)
5. If a client misses three appointments, the client will be discharged.
6. If a client chooses to not actively participate in treatment, he/she may be discharged.
7. A client's refusal to pay for a service is grounds for discharge.
8. Each session will begin and end on time. If a client is more than 10 minutes late, he/she will be considered as a no-show.
9. Clients may be asked to give random urine drug screens or alcohol breathalyzer screens on a weekly basis. If the client refuses, he/she may be discharged at the discretion of the program directors. Clients receiving two positive urine or breathalyzer screens may be discharged from the program at the discretion of the program directors. Clients will be monitored while giving urine.
10. If a client appears to have used illicit drugs or alcohol, the client will be asked if he/she is "using." If he/she states "no" he/she will be asked to give a urine sample. If he/she refuses they will be discharged and referred for treatment. If the drug screen shows up negative, the Clinic will pay for the test. Clients will not be treated when under the influence of any illicit drug or alcohol.
11. All clients are expected to maintain the confidentiality of other clients.

Client Grievance Procedures

Clients have the right to discuss treatment issues, and if necessary to review with the Director, disagreements about treatment, discharge, or change in status. No retaliation will be taken against clients who present a grievance. Clients will first be asked to discuss concerns with his/her counselor. The counselor will attempt to resolve the client's concerns. If the client is unsatisfied, he/she can write his/her complaint to the Program Director and the Director will investigate. The Director will write a response to the client within five days. The Director will offer possible remedies and discuss with the client. If the client is dissatisfied with the response from the staff, they can write the following impartial agency: Equal Employment Opportunity, 111 Market Place, Baltimore, MD 21201, phone number 410.962.3932.

Integrative Counseling, LLC

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Client Copy

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Integrative Counseling, LLC

Phone and Teletherapy Policies

Client Copy

Telephone and Internet Session – Teletherapy or Telepsychiatry

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