



PROVIDING COUNSELING, TRAINING, AND MOTIVATIONAL SPEAKING TO MEET YOUR EMOTIONAL AND BEHAVIORAL MANAGEMENT NEEDS.

Client Registration Form

Today's date: _____

A. Identification

Client name: _____ Date of birth: _____ Age: _____

Nickname or goes by: _____ Social Security #: _____

Parent/Guardian name: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ E-mail: _____

Please indicate any calls/e-mails restrictions: _____

B. Referral: Who gave you our name to call?

Name: _____ Phone: _____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation Christian Catholic Jewish Islamic Buddhist Hindu

Other (specify): _____

Ethnicity/national origin: _____ Race: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

May I tell your medical doctor so that he/she can be fully informed and we can coordinate your treatment? Yes No

F. Insurance Information

Insurance company: _____

Policy Number/Id: _____

Primary insurance holder name: _____ Date of Birth: _____

Client relationship to primary insurance holder: _____

Specialist / Mental health Co-pay (if known): _____

G. Your current employer / school

Employer/School Name: _____

Address: _____

Phone: _____

Calls will be discreet, but please indicate any restrictions: _____

H. Emergency information

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

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I. Is there any other information you think we should know?

J. Signature

Signature of client or his or her personal representative Date

Printed name of client or personal representative Relationship to the client

Description of personal representative's authority



PROVIDING COUNSELING, TRAINING, AND MOTIVATIONAL SPEAKING TO MEET YOUR EMOTIONAL AND BEHAVIORAL MANAGEMENT NEEDS.

Consent For Service and Privacy Practices

This form is an agreement between you and The S.E.L. Group. When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.theselgroup.com, or by calling us at, 336-285-7173.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by contacting our office in writing. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority



PROVIDING COUNSELING, TRAINING, AND MOTIVATIONAL SPEAKING TO MEET YOUR EMOTIONAL AND BEHAVIORAL MANAGEMENT NEEDS.

Agreement to Pay for Professional Services

I request that The S.E.L. Group provide professional services to _____,
and I agree to pay The S.E.L. Group's fee or my insurance copay of \$ _____ per session for these services.

EAP Authroization # _____ Number of Sessions _____

Private Pay Fee Schedule

| | |
|--|-----------|
| Initial Session Fee / Clinical Assessment | \$ 60.00 |
| Individual Therapy | \$ 60.00 |
| Couple's Therapy (per person) | \$ 60.00 |
| Child(ren) Play Therapy | \$ 60.00 |
| Family Therapy (per family) | \$ 100.00 |
| Legal Proceedings (per appearance) | \$ 150.00 |
| Cancellation notices within a 24-hour period | \$ 25.00 |

I agree that this financial relationship with The S.E.L. Group will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by The S.E.L. Group to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

Signature of client (or person acting for client) Date

Printed name

If not client relationship to the client

Client Bill of Rights

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations**. After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our office to arrange how to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our office. You must also tell us the reasons you want to make the changes.
5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our office and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing.

Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our office, by phone or email.

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse audio or video recording of sessions (but you may ask for it if you wish).
- Refuse to answer any question or give any information you choose not to answer or give.
- Know if your therapist will discuss your case with others (for instance, supervisors, consultants, or students).
- Ask that the therapist inform you of your progress.