Providence Counseling, LLC **Denise Bumgarner, LPC**
2217 Princess Anne Street Suite 327 Fredericksburg VA 22401
540-737-8120

New Client Registration Form

Client Information

Full Name:________________________________Birth Date:________Marital Status:__________
First Middle Initial Last

Address:____
Street City State Zip code

Home phone ________________Cell phone:___________________.Gender:_________________

Work Phone:___________________Referred by:_______________________________________

Last school grade completed:_______________Client's Social security Number:______________

Name of School or Employer:____

Name and ages of persons living in the household:______________________________________

List Current Medical Conditions?____

Medications?____ Physician:_______________

Briefly state why are you seeking treatment?____

____

Parent or Responsible Party (if other than the client)

Name:_____________________________Birth Date:________Relationship to Patient:__________
First Middle Initial Last

Name of School or Employer (optional):____

I HAVE READ THE INFORMED CONSENT/CONFIDENTIALITY AGREEMENT AND AGREE TO THESE CONDITIONS OF TREATMENT. ADDITIONALLY, I HAVE RECEIVED THE POLICIES AND PROCEDURES FORM AND AGREE TO ADHERE TO THESE CONDITIONS.

CLIENT SIGNATURE:______________________________________DATE:________________

GUARDIAN SIGNATURE (IF APPLICABLE):_________________________DATE:________________

HIPAA Notice

I HAVE RECEIVED THE NOTICE OF HIPAA PRIVACY PRACTICES FOR PROVIDENCE COUNSELING CENTER AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW IT.

CLIENT SIGNATURE:______________________________________DATE:________________

GUARDIAN SIGNATURE (IF APPLICABLE):_________________________DATE:________________

Insurance Information

Name of Insured:____________________Social Security Number:________________

ID number:______________________Relationship to Client:____________________

Primary Insurance Company or EAP program to be billed:________________________

Group Number:_____________________Birth date of Insured:__________________

Address of Insured:____
Street or PO Box City State Zip code

Address of Insurance Company or EAP program:_______________________________

Phone Number of Insurance Co. or EAP program:______________________________

Contact Person:____

Status of Deductible for Current year:______________Co-pay amount:_____________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE REPRESENTATIVES OF PROVIDENCE COUNSELING CENTER TO RELEASE TO MY INSURANCE COMPANY OR EAP PROGRAM INFORMATION CONCERNING MY TREATMENT AND HEREBY ASSIGN TO PROVIDENCE COUNSELING CENTER ALL OF MY PAYMENTS FOR PSYCHOLOGICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS AT PROVIDENCE COUNSELING CENTER. I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO MY ACCOUNT AND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY FEES AND CHARGES NOT COVERED BY MY INSURANCE OR EAP COMPANY.

SIGNATURE:____

PRINTED NAME:____

DATE:_______________________.

Providence Counseling, LLC **Denise Bumgarner, LPC**
2217 Princess Anne Street Suite 327 Fredericksburg VA 22401
540-737-8120

NOTICE OF INFORMATION PRACTICES

This notice describes how information about you may be used or disclosed. Please review it carefully.

1. Providence Counseling Center may use and disclose protected health information (The term "health" includes mental or behavioral health issues.) for treatment, payment, and healthcare operations. Examples include but are not limited to: Treatment plan updates, referrals to other mental health providers, insurance companies for coordination of benefits. All individuals working at Providence Counseling Center sign and maintain a confidentiality agreement in order to protect all clients' health information. In the future, Providence Counseling Center reserves the right to implement electronic billing practices, and/or request treatment extension in an electronic fashion.

2. Providence Counseling Center is permitted or required to use or disclose protected health information without an individual (or guardian's) written consent or authorization. Examples of this include but are not limited to: judicial proceedings, law enforcement purposes, and disclosure to avert a serious threat to health or safety.

3. Providence Counseling Center will not make any other use or disclosure of a client's protected health information without the individual's written authorization. The client may revoke consent/authorization at any time in a written statement. When consent is obtained disclosure is limited to the minimum amount of information necessary for purposes of the disclosure.

4. Psychotherapy notes (defined as notes recorded by a mental health provider documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session) are afforded special privacy protections. Psychotherapy notes are separated from the rest of the individual's medical record. In most circumstances written client consent is required before notes can be disclosed to anyone. Psychotherapy notes are excluded from the provision that gives clients the right to see and copy their health information. Limited uses/disclosure of psychotherapy notes without client consent is authorized in certain circumstances. These circumstances include but are not limited to: When mandated by law, when sent to a medical examiner, when required for enforcement of regulations by Health & Human Services.

5. Providence Counseling Center may at times contact the client by phone to provide appointment reminders or to discuss information regarding healthcare benefits with the client.

6. Providence Counseling Center will abide by the terms in this notice currently in effect at the time of disclosure.

7. Providence Counseling Center reserves the right to change the terms of this notice and to make provisions effective for all healthcare information it maintains.

8. Providence Counseling Center will provide clients with a copy of any revisions of its notice of information practices at the time of their next visit or last known address. Copies may also be obtained at our office or requested by phone.

9. Any client may file a complaint to Providence Counseling Center and to the Secretary of Health and Human Services if they feel their rights have been violated. To file a complaint with Providence Counseling Center please put the complaint in writing and address it to: HIPAA Compliance Officer, *2217 Princess Anne Street Suite 327 Fredericksburg VA 22401*. The HIPAA Compliance Officer will address ALL complaints.

10. It is Providence Counseling Center's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

I have read and understand my rights as a client and Providence Counseling Center rights as a provider under this Notice.

Client Name ____

Client/Guardian's Signature ____ Date __________