Elizabeth Rogers Counseling, LLC
Elizabeth Rogers, LCSW
5099 E Blue Lupine Dr. Suite 215, Wasilla AK 99654
Phone: (907) 521-0327
Fax: (907) 313-1381

Client Registration Form

Date: _____
Client's Legal Name: _____ Date of Birth: _____
(Last) (First) (Middle)
Mailing Address: _____
Home Address: _____
Primary Phone #: _____Client's Social Security #: _____
Client's Employer: _____Work Phone #: _____
If you are filling out this page for yourself, please proceed to the next page.

1st Guardian's Name: _____Date of Birth: _____
(Last) (First) (Middle)
Mailing Address: _____
Home Address: _____
Primary Phone #: _____
Guardian's Social Security #: _____
Relationship to Client: _____

2nd Guardian's Name: _____Date of Birth: _____
(Last) (First) (Middle)
Mailing Address: _____
Home Address: _____
Primary Phone #: _____
Guardian's Social Security #: _____
Relationship to Client: _____

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Form of Payment for Services

Please provide your insurance card(s) for your initial visit.

PRIMARY INSURANCE INFORMATION:
Insurance Company Name: _____
Claims Address: _____
Policy Holder's Name: _____ Relation to Client: _____
Policy I.D. Number: _____ Group: _____
Policy Holders SSN: _____ DOB: _____

SECONDARY INSURANCE INFORMATION:
Insurance Company Name: _____
Claims Address: _____
Policy Holder's Name: _____ Relation to Client: _____
Policy I.D. Number: _____ Group: _____
Policy Holders SSN: _____ DOB: _____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME OR MY CHILD BY ELIZABETH ROGERS COUNSELING, LLC. MY INSURANCE WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE ELIZABETH ROGERS COUNSELING, LLCURATE INSURANCE INFORMAION TO ELIZABETH ROGERS COUNSELING, LLC. I AM RESPONSIBLE FOR ANY PORTIONS OF MY BILL AT THE TIME THAT SERVICES ARE RENDERED, UNLESS INSURANCE IS PREDETERMINED TO COVER IT BY ELIZABETH ROGERS COUNSELING, LLC. I HEREBY AUTHORIZE PAYMENT BY MY INSURANCE DIRECTLY TO ELIZABETH ROGERS COUNSELING, LLC. I FURTHER AUTHORIZE RELEASE BY ELIZABETH ROGERS COUNSELING, LLC OF ANY INFORMATION NECESSARY TO MY INSURACE COMPANY FOR PAYMENT OF CLAIMS.
Client or Guardian Signature: _____ Date: _____

Please sign here to give your counselor consent to provide mental health services to the identified client. If the client is a minor, your signature confirms your legal authority to sign on behalf of the minor. If you have any questions, feel free to ask.

Client or Guardian Signature: _____ Date: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ELIZABETH ROGERS COUNSELING, LLCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect May, 01, 2018 and will remain in effect until we replace it. We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. Elizabeth Rogers Counseling, LLC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, you may give us additional written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

I hereby acknowledge receipt of ELIZABETH ROGERS COUNSELING, LLC Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

Client or Guardian Signature: _____ Date: _____

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Commitments and Expectations

Please carefully review and initial the following items and sign at the end of the document to indicate your agreement with them. If you have any questions or concerns, please let us know so that we may address them. Thank you.

COMFORT ZONE

With consideration of the work we do at ELIZABETH ROGERS COUNSELING, LLC, we request clients recognize the facility, and the grounds, as a safe and comfortable zone for all clients. Things we request: Scent Free – Please refrain from using perfume, colognes, and other scents such as essential oils. Scents can trigger traumatic flashbacks and allergic responses for other clients. **INITIAL _____**

Medical - Cigarettes, cigars, pipes; electronic or natural, are not allowed within the facility or 20ft from building. **INITIAL _____**

Children - It is often unsuitable to bring children into your personal or couples therapy session, please do not leave them unattended in our facility. You may be asked to reschedule if they become unruly and disrupt other clients experience at our facility. **INITIAL _____**

APPOINTMENTS

Unless otherwise noted, therapy appointments last fifty-three (53) minutes. **INITIAL _____**

We will attempt to place a courtesy call or text to remind you of your appointment. However, it is ultimately your responsibility to keep the appointment you have scheduled with ELIZABETH ROGERS COUNSELING, LLC. In the event you are unable to keep an appointment, you must notify us at least twenty-four (24) hours in advance. If you do not call to cancel or reschedule your appointment, you will be charged the full rate for the missed session. Missed appointment fees are due and payable before the next scheduled session. Insurance and/or other third-party coverage cannot and will not be billed for no-shows or late cancellations. **INITIAL _____**

We value your time and will do our best to run on time for your appointments. However, please keep in mind that situations arise that require extra time and attention, in person or by telephone, and may cause us to run late. We may choose to spend extra time with those in crisis, as we would with you in your time of need. **INITIAL _____**

PAYMENT FOR SERVICES

Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. All new clients are asked to pay the full amount of their first visit at the time of that visit. Insurance will still be billed, and any overpayment will be applied toward future sessions or reimbursed. **INITIAL _____**

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If you use private insurance, we require payment of the portion of your bill not covered by your insurance at the time of your appointment. Many new insurances have large deductibles or long waits for payment. Given that timely payment for our services is expected, if your account becomes more than 60 days past due, we will expect you to set up a payment plan with us. When your insurance company reimburses us and a credit appears on your account, a reimbursement check will be written to you the following billing cycle. **INITIAL _____**

If your account becomes 90 days past due without any attempt on your part to set up a payment plan, or if you do not abide by your payment plan, we reserve the right to cease providing services to you. All accounts reaching the 120-day mark will be turned over to a collection agency. All fees associated with the collection of accounts will be at the client's expense. In that event, we will provide you with the names of other qualified providers with whom you may seek treatment. **INITIAL _____**

For those with more than one insurance coverage, we will bill your primary insurance first. Once payment is received from that primary insurance company, we then will bill your secondary insurance company one time. Please remember that insurance is *a contract between you and your insurer*. We are happy to help ensure payment of your benefits; however, we cannot and will not become involved in disputes concerning deductibles, copayments, secondary insurance, or what insurance companies refer to as "usual and customary" reductions. **INITIAL _____**

If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. **INITIAL _____**

Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and providers before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All services billed in this office are considered covered unless limited by your specific insurance policy. I**NITIAL _____**

Returned checks will incur a $50.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $50 service charge to pay the balance prior to receiving services from our staff. Stop payments constitute a breach of payment and are subject to the $50 service fee and collections action. **INITIAL _____**

<u>INSURANCES WE WON'T BILL/PATIENTS WE WON'T ACCEPT INTO THE PRACTICE</u>
I am not currently eligible for Medicare, Medicaid, TriCare. I will notify Elizabeth Rogers Counseling LLC in writing immediately if I become eligible for these payers, thus terminating my care from Elizabeth Rogers Counseling LLC, who WILL NOT accept new patients with Medicare, Medicaid, TriCare, nor bill these payers if patients switch after becoming established with Elizabeth Rogers Counseling LLC. **INITIAL _____**

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Communications Policy

Contacting Me

When you need to contact Elizabeth Rogers, LLC for any reason, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (907) 521-0327 You may leave messages on the voicemail, which is confidential.
- By text message (see below for details.)
- By email (see below for details.)
- If you wish to communicate with me by normal email or normal text message, please read and complete the Consent For Non-Secure Communications form included with these office policies.

Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security and I am not prepared to watch them closely for important messages from clients.

It is important that we be able to communicate and also keep the confidential space that is vital to therapy. Please speak with me about any concerns you have regarding my preferred communication methods.

Response Time

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within 48 hours (weekends are excepted from this timeframe.) I may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when I am unable to receive or respond to messages, such as when out of cellular range or out of town.

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call 911 or the city-wide crisis line at (907) 376-2411

If you need to contact me about an emergency, the best method is:

- By phone (907) 521-0327

If you cannot reach me by phone, please leave a voicemail and follow up by contacting the appropriate crisis line at 911 or (907) 376-2411

Please note that SMS (normal phone text messages) are not designed for emergency contact. SMS text messages occasionally get delayed and on rare occasions may be lost. So, please refrain from using SMS as your sole method of communicating with me in emergencies.

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CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____

AUTHORIZE: Elizabeth Rogers, LCSW

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

☐ Information related to the scheduling of meetings or other appointments
☐ Information related to billing and payment
☐ Completed forms, including forms that may contain sensitive, confidential information
☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
☐ My health record, in part or in whole, or summaries of material from my health record
☐ Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

☐ Unsecured email at elizabethrogerscounseling@gmail.com
☐ SMS text message (i.e. traditional text messaging) that is unsecure

TERMINATION

☐ This authorization will terminate _____ days after the date listed below.
OR
☐This authorization will terminate when the following event occurs: _____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____
(Signature of client) Date

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I HAVE REVIEWED THE COMMITMENTS AND EXPECTATIONS SET FORTH IN THIS DOCUMENT AND AGREE TO ABIDE BY THEM WHILE I AM WORKING WITH ELIZABETH ROGERS COUNSELING, LLC.

Client or Guardian Signature: _____ Date: _____

The Board of Professional Counselors, which regulates all licensed professional counselors, requires that we provide the following contact information: Board of Professional Counselors Division of Occupational Licensing PO Box 110806 Juneau, AK 99811-0806 Phone: (907) 465-2551