RESTORATION and Peace

Provider _____ Date of Referral _____

CLIENT REGISTRATION FORM & PAYMENT AGREEMENT

Client Contact Information:

Name _____ _____/_____/_____
First M.I. Last Date of birth

Address _____
Street Apt. # City State 9-digit zip code

Cell Phone (_____) _____ Home Phone (_____) _____
[Okay to leave message or text? Y N] [Okay to leave message? Y N]

Email address _____ Age of client _____

*What is your preferred method of communication with your therapist? _____

Relationship or Marital Status _____

Gender Identification: _____ Prefered pronoun _____

Employer/School _____ Work Phone _____

If a student, Student status: ☐ Full-time, ☐ Part-time

Emergency contact - Spouse/Significant other, parent: _____ Cell phone # _____

Address, if different _____
Street Apt. # City State 9-digit zip

*** Please indicate who will be responsible for billing ☐ Self ☐ Parent ☐ Spouce ☐ Other ____

Name: _____

Address: _____ _____ City _____State _____Zip_____

Parent/Guardian/Caregiver information, if client is a minor, please complete below:

**Address need only be completed if different than client's*

Parent/Guardian/Caregiver _____ Parent/Guardian/Caregiver _____

Address* _____ Address* _____
Street apt # Street apt. #

_____ _____
City State 9-digitZip City State 9-digit Zip

Home Phone ( ) _____ Home Phone ( ) _____

Employer Name _____ Employer Name _____

Work Phone ( ) _____ Work Phone ( ) _____

Date of Birth _____/_____/_____ Date of Birth _____/_____/_____

Insurance Information (Please fill out below. We also need a copy of your insurance card, front and back sides.)

Primary Insurance Carrier: _____

Address: _____
Street City State 9-digit Zip

Policy Holder (name on card) _____ Insurance Phone Number ( ) _____

Birth date of client ___/____/_____ Policy/Member # _____ Group # _____

If you are insured under *another subscriber*, please include **below information** of primary policy holder (named on your card):

Name: _____ Birth date of policy holder: ____/_____/_____

Address of Policy Holder: _____

Your relationship to person named above (e.g., spouse, child, etc) _____

Secondary Insurance Carrier: _____(policy holder on card & BD)_____

Address of who to be billed _____
Street City State 9-digit zip

Phone Number ( ) _____ Policy Holder _____ (BD____/___/_____)

Policy/Member # _____ Group # _____

Payment Consent/Agreement:

PLEASE NOTE: The client is ultimately responsible for the payment of all services received through Restoration & Peace. If your psychotherapist bills a medical insurance company for services, this is done as a courtesy to the client and is not a substitute for the client's responsibility for payment for services.

Signature on File If you would like our company to file claims with your insurance carrier, the *insured's signature* is required below.

- I authorize use of this signature form on **all** my insurance submissions.
- I authorize Restoration & Peace practictioners to release to my insurance company any medical information necessary to process my claims.
- I understand that **I am responsible** for my payment of my bill.
- I authorize Restoration & Peace and/or their prefered billing company to act as my agent in helping to obtain payment from my Insurance Company(s).
- I authorize payment directly to my Restoration & Peace practictioners.
- I permit a copy of this authorization to be used in place of the original.
- I understand that this consent may be revoked by me at any time in writing, except to the extent that action has already been taken. This consent remains valid unless expressly revoked.
- I hereby release Restoration & Peace and/or their prefered billing company from any legal responsibility or liability that may arise from the act of filing my insurance claims.
- **PLEASE NOTE - I understand that 24 hours notice is required to cancel an appointment.** If less than 24 hours is given I understand I will be charged for th**e missed appointment or late cancellation.** Insurance companies do not pay missed appointment charges.
- I understand that I am responsible for paying self-pay and deductible amounts within 30 days after being billed. **Any amounts of more than $250 balance may result in the need to suspend or terminate therapy until payment is received.**
- PLEASE **NOTE: A late fee of $25 per month will be charged each month if payments for copays and deductables are not received after three months of billing date.**

Client's Name (please print) _____ Signature _____ Date _____

Signature of Therapist _____ Date _____

******* OR Self-Pay Fee for Psychotherapy:**

Your fee will be $ _____ per _____ minute session.

Client's signature _____ Date: _____

Therapist's signature _____ Date: _____

11650 Arbor Street ▪ Suite 106 ▪ Omaha, NE 68144 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

Referral/Clinical Information:

How did you find out about our services? _____

What type of services are you seeking/expecting? (Please check all that apply to you)

_____ Individual Counseling
_____ Group Counseling
_____ Couples/Family Counseling
_____ Substance Abuse Counseling

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

Mental Health History:

Have you received counseling before? ***Yes*** ***No***

If yes, when, where, and with whom? _____

_____

Have you ever experienced any of the following?

_____ A recent and/or important loss (please specify) _____
_____ Physical Abuse
_____ Sexual Abuse/Molestation
_____ Sexual Assault
_____ Verbal/Emotional Abuse
_____ Suicidal Thoughts or Feelings
_____ Homicidal Thoughts or Feelings

Are you having current difficulties with any of the following?

_____ Academic Performance
_____ Anger Management
_____ Body Image
_____ Career Planning Issues
_____ Decision Making Issues
_____ Divorce/Separation Issues
_____ Family Relationships
_____ Financial Problems
_____ Learning Disabilities
_____ Legal Problems
_____ Other stress (please specify) _____
_____ Loneliness/Social Isolation
_____ Peer Relationships
_____ Phase of Life Issues
_____ Pregnancy Issues (past, present)
_____ Racial/Cultural Issues
_____ Romantic Relationships
_____ Self-Confidence/Self-Esteem
_____ Sexual Identity Issues
_____ Spirituality
_____ Unemployment

How well are you getting along psychologically at this time?

_____ Very well, the way I want to.
_____ Quite well, no important complaints.
_____ Fairly well, but have ups and downs.
_____ So-so, can keep going with effort.
_____ Quite poorly, can barely manage.
_____ Very poorly, can't manage.

SYMPTOM CHECKLIST

I**nstructions:** The questions below ask about things that might have bothered you or caused problems. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**. If the problem has happened in the past, even if it is resolved, please check "In the past."

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	In	None Not at all	Slight Rare, less than 1-2 days	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest **Domain Score** (office use only)
I.	Little interest or pleasure in doing things?		0	1	2	3	4	
	Feeling down, depressed, empty or hopeless?		0	1	2	3	4	
II.	Feeling more irritated, grouchy, or angry than usual?		0	1	2	3	4	
	Feeling more tired than usual for no reason?		0	1	2	3	4	
	How long do these feelings usually last?							
	What is the longest they have ever lasted?							
III.	Sleeping less than usual, but still have a lot of energy?		0	1	2	3	4	
	Starting more projects than usual or doing more risky things than usual?		0	1	2	3	4	
	Feeling unusually high, charged up, excited or restless?		0	1	2	3	4	
	Had other people ever said that you were too high, charged up, excitable, or talkative?		0	1	2	3	4	
	How long have these moods usually last?							
	What is the longest they have lasted?							
IV.	Feeling nervous, anxious, frightened, worried, or on edge for days at a time, even when you didn't have anything special to do?		0	1	2	3	4	
	Feeling panic or being frightened?		0	1	2	3	4	
	Avoiding situations that make you anxious?		0	1	2	3	4	
	Have these feelings ever bothered you on and off for six months or more at a time? If so, how long did they last and when did this occur?							
	Feeling very afraid of certain things like heights, animals, needles, the sight of blood, lightening, etc?		0	1	2	3	4	
	What were you afraid of?							
	Feeling so afraid to leave home by yourself that you wouldn't go out?		0	1	2	3	4	
	Feeling afraid to go to supermarkets, go into tunnels, or use elevators?		0	1	2	3	4	
	Feeling so afraid of embarrassing yourself in public that you would not do certain things like eating in a restaurant, using a public restroom, or speaking out in a room full of people?		0	1	2	3	4	
	Did you see a doctor because of this and if so, what did the doctor tell you about these symptoms?							
	Having a lot of physical problems that have forced you to see different doctors?		0	1	2	3	4	
V.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?		0	1	2	3	4	

	Feeling that your illnesses are not being taken seriously enough?		0	1	2	3	4	
	Doctors having difficulty finding what caused the problems?		0	1	2	3	4	

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RIGHTS & CONSENT TO TREATMENT

- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of Restoration & Peace without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- I understand that if Restoration & Peace shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent for Restoration & Peace clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians and nutritionists actively collaborate and consult about mutual cases, as well as share clinical notes.
- I understand that my therapist may consult and share clinical information with her supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. She may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Restoration & Peace.
- I understand that all communications with Restoration & Peace staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although any Restoration & Peace -based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager. Restoration & Peace reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature _____ **Date** _____

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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and Restoration & Peace. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here:

_____.

When we see you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others under the circumstances described in our Notice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.restorationandpeace.net or by calling us at 402-979-6060. If you have any questions regarding the Notice or your privacy rights, you can also contact Tracey Pearson, LMHP at TPearson@RestorationandPeace.net or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to the email address above about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Restoration & Peace's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understand its content, and agree to its stipulations.

Signature:_____ Date:_____

Printed Name:_____ Relationship: _____

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

☐ ***Client Refuses to Acknowledge Receipt:***

Signature of authorized representative of this office or practice:

_____

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OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, and sign below. You may request a copy for your records.

Restoration & Peace is a business office where of mental health professionals practice. Your contract for services is with our office and applies to any and all providers you may see here.

Appointments: All office visits are by appointment and scheduled with your psychotherapist directly. Please arrive on time, as you cut down on your appointment time when you arrive late. The usual length of an appointment is 45-50 minutes. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment, which will result in a late cancellation charge.

Payment: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, HSA, VISA or Master Card.

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $60 for the appointment. Please note: appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminder calls/texts are a courtesy, and you will be billed for late cancellations and no- shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

Insurance: As a courtesy to you, we will bill rendered services to your insurance carrier if your psychotherapist is a provider of that network. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Restoration & Peace for services rendered and you will be responsible for handling any disputes with your insurance carrier. It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility. Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file. *Please note:* treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers, may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

Outstanding Balance: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Restoration & Peace does not receive payment in full for services rendered, your treatment may be discontinued. If you are unable to pay your balance in full, a signed payment plan agreement will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment, and you desire to resume receiving services at Restoration & Peace, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and will also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

Additional Services: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $90/hour.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Please note: No provider at Restoration & Peace will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Restoration & Peace (5+ sessions with one provider), and at

the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

Changes to the Policy: Restoration & Peace reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____I have read, understand, and agree to the above policies.

_____I authorize Restoration & Peace to release any information acquired in the course of my therapy to my insurance company as needed.

_____I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

_____I have been offered a copy of these policies to take with me if I desire.

_____I have discussed these policies and addressed concerns and questions with the administrative staff if needed.

Initial and date by administrative staff if questions were addressed: _____

_____ _____

Signature of Client Date

_____ _____

Signature of parent or Legal Guardian Date