

**REGISTRATION INFORMATION
(PLEASE PRINT)**

Date: _____

RESPONSIBLE PARTY

Name: _____ Work Phone: _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

DOB: _____ Age: _____ Sex: M: ___ F: ___ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Pager or Cell: _____

Place of Employment: _____

Marital Status: Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Never Married: ___

Spouse's Name: _____ Work Phone: _____

DOB: _____ Age: _____ Sex: M: ___ F: ___ SSN _____

If other than above:

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Pager or Cell: _____

Place of Employment: _____

If Patient is a minor: Name: _____

DOB: _____ Age: ___ Sex: M: ___ F: ___ SSN: _____

Primary Care Physician: _____ Phone: _____

Who may we thank for referring you? _____

May I leave a phone message at your **home** identifying myself as "Ed Fenn" only? Yes: ___ No: ___

May I leave a phone message at your **home** clarifying an upcoming appointment? Yes: ___ No: ___

May I leave a phone message at your **office** identifying myself as "Ed Fenn" only? Yes: ___ No: ___

May I leave a phone message at your **office** clarifying an upcoming appointment? Yes: ___ No: ___

Is your office number your phone only or do you share the phone with others? Mine only: ___ Shared: ___

May I leave a message for you by e-mail? Yes: ___ home e-mail: _____ No: ___

INSURANCE INFORMATION

NO NEED TO WRITE OUT YOUR INSURANCE INFORMATION IF COPY CAN BE MADE OF YOUR CARD.
However, we will still need your signatures below.

Primary Insurance Carrier: _____ Phone: _____

Subscriber's Name: _____ Relationship to patient: _____

Subscriber employed by: _____ Phone: _____

DOB: _____ Insurance ID#: _____ Group/Policy #: _____

Claims address: _____

SECONDARY INSURANCE CARRIER: _____:Phone: _____

Subscriber's Name: _____ Relationship to patient: _____

Subscriber employed by: _____ Phone: _____

DOB: _____: Insurance ID#: _____ Group/Policy #: _____

Claims address: _____

CONFIDENTIALITY All information will be kept confidential and will be made available only to our professional staff. It will not be released to any outside individual or agency without your written permission. Your insurance company may request dates of service, diagnosis, amounts of charges, and certain information as to why services may need to be continued past current authorization by them. Information may be divulged as required by state law, valid court subpoena, or if your counselor believes you to be in imminent danger to yourself or another.

CONSENT FOR TREATMENT and AUTOMATIC TERMINATION OF TREATMENT:

I hereby authorize and consent to psychotherapy services provided by Mr. Ed Fenn. No promise, guarantee or warranty has been made regarding the result of treatment. The nature of the therapeutic relationship requires the person seeking treatment to notify the counselor in case of serious thoughts of suicide. If the counselor is not notified, a workable relationship does not exist. If the person seeking treatment attempts suicide or engages in behavior that reasonably is understood to be life-threatening, and does not first attempt to reach Mr. Fenn, then the person will be considered to be not seriously seeking healthy change, and further sessions will be limited to the time of transition to another counselor, a time likely not exceeding four to six weeks. Your signature below also attests to your understanding and consent to this requirement.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

Signature of Parent/Guardian if patient is a minor Date: _____

PAYMENT PROCEDURES

As a new patient, you are responsible for checking your benefits if you wish to use insurance for office visits. Our office is happy to assist with this, however; some insurance companies will give benefit information only to the subscriber.

We must have your benefit information by the second therapy session or you will be responsible for the full office visit fee at that time. Otherwise we will bill your insurance and you will be responsible for your co-payment at the time of service.

We are happy to complete two insurance forms and assist you with any problems with your insurance company. You must be aware, however, that the ultimate responsibility for your financial obligations lies with you.

In the event that insurance will not apply, we will work with you on a sliding scale, based on income. You will be required to present some proof of income in order for the office to determine your fee.

Because of the time and high cost of monthly billing, it will be very helpful if you make your co-payment at the time of the visit. Balances, which are left unattended upon termination of services, may be turned over to a collection agency, unless other arrangements have been made.

We require 24-hour notice for appointment cancellations. In the event that no notice is given within 24 hours, there will be a \$50.00 fee charged for the missed appointment. This fee is not covered by your insurance.

Litigation is very costly for a private practitioner due to the amount of time and disruption of schedule. Mr. Fenn prefers not to be involved in litigation. However, in the event he is subpoenaed or deposed, an initial payment of \$500.00 is to be paid **in advance** and a \$125.00 per hour fee for every hour thereafter. These costs are most likely to be the responsibility of the client involved in litigation. This is not a covered expense by your insurance company.

If reports, letters or other correspondence are required as a part of treatment then the charges are billed to the client and are not covered by insurance.

I fully understand the above procedures and will comply with them. Additionally, I authorize my insurance company, _____ to pay directly to Ed Fenn, LCSW for medical and/or major benefits for services rendered to patient _____. I also hereby authorize an exchange and/or release of information to my insurance company regarding diagnosis and /or treatment of my condition when same insurance company requests such aide in reimbursement, documentation of services, and utilization of services.

Signature of client or parent / Guardian if a minor Date: _____

Signature of second client (same family) Date: _____

ED FENN, LCSW

**Acknowledgement of Notice of Privacy Practices and
Consent to use and disclose your health information**

This form is an agreement between you, _____ and Ed Fenn. 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 here:
_____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide on 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 or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are acknowledging that you were given the opportunity to read, to discuss the content, and to receive a copy of Ed Fenn’s Notice of Privacy Practices. You are also agreeing to let us use your information here and send it to others for treatment, payment and operational purposes. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

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

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from Ed Fenn.

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 operational 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 agree to these limitations. However, if we do agree, we will do as you asked.

After you have signed this consent, you have the right to revoke it (in writing to Ed Fenn telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and 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

Ed Fenn’s signature