Veronica Lichtenstein LMHC

LET'S TALK ABOUT IT

# CLIENT REGISTRATION

CLIENT NAME_____
LAST FIRST MIDDLE

ADDRESS_____

CITY _____ STATE _____ ZIP_____

HOME PHONE _____ CELL PHONE_____

SS# _____ SEX _____ DATE OF BIRTH _____ AGE_____

IF STUDENT: NAME OF SCHOOL _____ GRADE _____

INSURANCE POLICY HOLDER NAME _____ DOB _____

PARENT / GUARDIAN (If Patient Is A Minor) _____

CONTACT NUMBER FOR PARENT/GUARDIAN _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

PHONE NUMBER _____

**Best Phone Number to Receive Text Reminders** _____
**Name of Contact (If client is a minor)** _____

## OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions
2. I authorize the release of information to my insurance company
3. I understand that I am responsible for the full amount of my bill for services provided
4. I authorize direct payment to my service provider
5. I hereby permit a copy of this to be used in place of an original

It is your responsibility to pay any deductible amount, copay, co-insurance amount or any other balance not paid by your insurance at the date and time services are provided. No checks are accepted – Credit card or Cash only. If your account goes into collection, there will be a 20% fee added to your balance _____ Initials

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## CONSENT TO TREATMENT

I hereby authorize Veronica Lichtenstein LMHC, LLC. to administer mental health/psychiatric treatment. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that Veronica Lichtenstein LMHC, LLC. may be obligated to release information to my insurance company from my medical records as determined and required by my company's' guidelines and hereby authorize the release of such information. I authorize the release of pertinent information for collection purposes should it be necessary. I hereby consent to receive consumer survey material following completion of treatment for the purposes of evaluating my satisfaction with the effectiveness of services rendered by Veronica Lichtenstein LMHC, LLC.

_____ Initials

For minors: I represent and warrant that all information submitted is true and correct and that I have complete and proper authority to involve the above referenced minor client for treatment at Veronica Lichtenstein LMHC, LLC. I understand that Veronica Lichtenstein LMHC, LLC. is relying upon my representation to accept the minor child as a client and I shall hold harmless and indemnify Veronica Lichtenstein LMHC, LLC. as the result of any representations which are not true and correct.

_____ Initials

## POLICIES AND PROCEDURES

Veronica Lichtenstein LMHC, LLC. maintains the highest of professional and ethical standards. To serve our clients to the best of our ability, we request that you review the following policies and procedures prior to your initial session. Take note of the added Social Media Policy and her Telehealth Informed Consent. Should you have any questions or concerns prior to signing acknowledgment of these terms, please discuss these issues with your therapist or the office manager at **561-903-TALK (8255)**.

**Emergency Services:** Veronica Lichtenstein LMHC, LLC. **does not** provide 24-hour emergency coverage. Should you have a potentially suicidal/homicidal situation, please call **911 IMMEDIATELY** or go directly to the emergency room of the nearest hospital based on the severity of the situation. You may also contact the National Suicide Prevention Lifeline 24 hours a day / 7 days a week if you are experiencing a clinical emergency at **800-273-8255**.

_____ Initials

**Confidentiality of Relationship:** All information given by you or your family is treated as confidential and may be released only upon your written consent or as required by law. The legal limitations to confidentiality include: Suspected or reported child abuse/neglect, suspected or reported situations in which your therapist believes to be potentially life threatening to yourself or others, or should a court order require your therapist to provide information to the courts.

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**Canceled / Missed Appointments:** Appointments must be canceled by midnight before your scheduled appointment. You can text/call 561-903-8255 or email V@VeronicaListens.com or Talk@VeronicaListens.com to notify us of your cancellation. We reserve the right to charge a fee for failed appointments. Your insurance company will not pay for missed or failed appointments; therefore, you will be responsible for this fee which is currently $75.

_____ Initials

**Phone Contacts:** Telephone calls, consultations and correspondence will be billed at therapy rate of $100 per hour in 15-minute increments. Although most insurance companies do not cover phone sessions, they have made exceptions during the Covid-19 Quarantine. Presently, Veronica is only doing Telehealth via Doxy.me.

https://doxyme.intercom-attachments-3.com/i/o/196471250/6e2e76fb683f48acf0c74fea/Patient+Flyer+Customized+%282%29.pdf

**Court Testimony:** We do not believe that it is advantageous to expect your therapist to testify in court. Veronica Lichtenstein, LMHC LLC does not make court appearances. You can read more about court documents and subpoenas in her Policy and Informed Consent for Couples on her website.

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**Sessions:** Please respect that your sessions are scheduled for 45-50 minutes. Most insurance companies pay for a 45-minute session unless otherwise noted in your original paperwork. We ask that you arrive for your session on time. Your session will be limited to the original scheduled time. Should your therapist be responsible for the session starting late, you will receive your entitled session time.

_____Initials

**Co-Pays and Deductibles:** Our office is unique in that there is no support staff on sight and all monies are collected over the phone by submitting a credit card to be kept on file. Cash is also accepted. Co-pays, deductibles, late fees are due prior to appointment to avoid rescheduling.

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**Insurance Premiums:** From time to time we receive notification that a policy has lapsed or is in a "grace period" due to non-payment of the premium. Please be advised that when we receive such a notification we will suspend your appointments until the insurance company confirms the policy is back in effect. Or you will have the option of paying the full rate for the session.

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## TEXT AND EMAIL CORRESPONDENCE

I acknowledge the use of secured and unsecured text and email correspondence to and from the office of Veronica Lichtenstein LMHC, LLC. and release any liability to Veronica Lichtenstein LMHC, LLC. should any confidential information be transmitted. I have also read Veronica Lichtenstein, LMHC LLC Social Media Policy.

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## INSURANCE WAIVER

All services that we provide to you in our office will be billed to your insurance company. Any services not paid by your insurance company will be your responsibility. Due to the magnitude of changes within the insurance companies, we are unable to pre-verify benefits for all insurances, as many companies subcontract their outpatient mental health benefits. Clients need to be aware of their own insurance benefits and what will be covered by their plans. It is your responsibility to obtain prior authorization if it is required by your insurance company. In addition, it is the clients' responsibility to be sure that your provider is participating with the insurance plan.

_____Initials

## HIPAA SIGNATURE

I **acknowledge receipt of / decline a copy (circle one)** of HIPAA notice of Privacy Practices and the Office Policies and General information agreement for psychotherapy services. This signature page will be placed in your medical chart. Should you have any questions please address them with our office staff or your individual therapist.

_____Initials

I hereby acknowledge that by signing below I accept and understand the above Office Billing and Insurance Policy, Consent for Treatment, Policies and Procedures, Insurance Waiver, and HIPAA Signature.

_____

Signature of Client Date Date

_____

Name of Client (Print)

_____

Witness / Therapist Signature Date