Capitol Hill Consortium for Counseling & Consultation LLC
650 Pennsylvania Avenue SE, Suite 440, Washington, DC 20003
P | 202.544.5440 **F** | 202.544.3004

PATIENT REGISTRATION FORM

PATIENT FULL NAME *(OTHER PARTICIPANTS)*	GENDER _____ PRONOUNS _____ Gender Insurance Has You Listed Under (if different) _____
PATIENT ADDRESS	
PATIENT CONTACT INFORMATION CELL EMAIL	*OTHER PARTICIPANTS* CONTACT & RELATIONSHIP TYPE: CELL EMAIL
AGE / DATE OF BIRTH (MM/DD/YYYY) / MARTIAL STATUS	
NAME OF EMPLOYER/ SCHOOL	SOCIAL SECURITY NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
NAME OF POLICY HOLDER DATE OF BIRTH	NAME OF POLICY HOLDER DATE OF BIRTH
POLICY NUMBER GROUP NUMBER	POLICY NUMBER GROUP NUMBER

RESPONSIBLE PARTY

RESPONSIBLE PARTY IS: ☐ PATIENT ☐ PRIMARY POLICY HOLDER ☐ SECONDARY POLICY HOLDER

RESPONSIBLE PARTY'S NAME AND DATE OF BIRTH (FIRST, M, LAST, DOB)	HAS THE RESPONSIBLE PARTY BEEN COURT-ORDERED? TO PAY MEDICAL BILLS? ☐ YES ☐ NO
ADDRESS	IF YES, WE ASK THAT YOU HAVE THAT PERSON SIGN AN AUTHORIZATION FORM.
TELEPHONE NUMBER	RELATIONSHIP TO PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER

EMERGENCY CONTACT
IN THE EVENT OF AN EMERGENCY WHO SHOULD WE CONTACT

NAME OF EMERGENCY CONTACT	RELATIONSHIP TO PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER
TELEPHONE NUMBERS HOME WORK CELL	

BILL AND PAYMENT POLICY

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND THE RESPONSIBILITY OF THE PATIENT. OUR STAFF WILL ASSIST YOU IN COMPLETING ANY FORMS NECESSARY TO EXPEDITE REIMBURSEMENT FROM INSURANCE CARRIERS AT NO ADDITIONAL CHARGE.

IF A PERSON OTHER THAN PATIENT (PATIENT'S SPOUSE OR PARENT) HAS ACCEPTED FINANCIAL RESPONSIBILITY FOR MEDICAL BILLS, A SIGNED CONSENT TO THAT AFFECT MUST BE ON FILE. OUR STAFF WILL GLADLY EXPLAIN OR ASSIST YOU WITH ANY ASPECT TO THIS POLICY.

AUTHORIZATION AND RELEASE

I, _____, HERBY AUTHORIZE CCCC TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED TO ME AND/OR MY DEPENDENTS.

FINANCIAL INFORMATION

CCCC RESERVES THE RIGHT TO CHARGE A 30% ATTORNEY FEE AND 15% INTEREST, IF REFERRED TO COLLECTIONS. IF I PAY FOR SERVICES WITH A CHECK, TELECHECK WILL REFER THE AVAILABILITY OF MY FUNDS. I UNDERSTAND THAT I WILL BE CHARGED A $25.00 RETURN CHECK FEE, IF MY CHECK IS RETURNED BY MY FINICIAL INSTITUTION/BANK. I ALSO UNDERSTAND THAT THERE IS A CANCELLATION FEE OF $100.00 FOR BROKEN OR MISSED APPOINTMENTS UNLESS NOTICE IS GIVEN AT LEAST TWO BUSINESS DAYS BEFOREHAND. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. EITHER THE ABOVE-NAMED CARRIER OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

SIGNATURE

I CERTIFY THAT ALL THE INFORMATION ON PAGE (1) ONE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I ALSO AGREE TO THE INFORMATION IN THE BILL AND PAYMENT POLICY, AUTHORIZATION AND RELEASE AND FINANCIAL INFORMATION SECTIONS OF THIS FORM. I ALSO AUTHORIZE THIS SIGNATURE FOR CLAIMS SUBMISSIONS. (*FOR PARENTS/GUARDIANS*: I ACKNOWLEDGE THAT I, _____, HAVE THE LEGAL AUTHORITY TO INITIATE, ACCESS, AND TERMINATE MENTAL HEALTH SERVICES FOR THE MINOR LISTED AS THE PATIENT ABOVE.

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF PATIENT IS A MINOR) **DATE**

PROVIDER SIGNATURE:	**DATE:**

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HIPAA Notification – Notice of Clinician's Policies & Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGIAL & MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you.
- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
- Payment is when I obtain reimbursement for your health care. Examples of payment include when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations include quality assessment and improvement activities, case management, care coordination, and business-related matters such as audits and administrative services.
- Use applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- Authorization is your written permission to disclose confidential mental health information. All authorizations to disclose information must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. Under circumstances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information.

I will also need to obtain an authorization before releasing your Psychotherapy Progress Notes, which are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or Psychotherapy Progress Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization under any of the following circumstances:

- Child Abuse – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally abused, physically abuse, sexually abused, or neglected, I must immediately report such knowledge or suspicion to the appropriate authorities.
- Adult and Domestic Abuse – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must report this belief to the appropriate authorities.
- Health Oversight Activities – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or you legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious threat to Health or Safety – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate authorities and/or individuals.
- Worker's Compensation – If I am treating your for Worker's Compensation purposes, I must provide periodic developmental reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

Your signature below serves as an acknowledgement that you have received the HIPAA notice.

Patient Name	Signature	Date
Other Participants Name	Signature	Date

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Consent for Treatment Agreement

Please read and initial beside each section indicating that you are aware and understand our policies.
If you have questions, please discuss with your clinician.

I. Evaluation and Diagnostic Procedures

a. The initial evaluation and diagnostic process may take up to 3 – 4 sessions. All sessions, including intake, are 45-53 minutes long depending on your provider. **INITIALS**

b. The initial evaluation will consist of clinical interview and may also include interviews with significant others, psychological testing and/or referrals to other specialists.

c. Treatment will consist of individual, group, couple, and/or family psychotherapy, as well as possible adjunctive psycho-educational or skill building services. Frequency is determined by the clinician's recommendation, scheduling availability, and the nature of the problem. Session frequency is typically weekly, and this may increase or decrease over the course of treatment.

d. Treatment may also consist of referral to a psychiatrist for psychopharmacological recommendations. CCCC does NOT have a psychiatrist on staff; a referral list is available. Collaboration with your primary care physician is desirable and other specialists will be referred to and collaborated with on an as needed basis.

e. Because therapy is the process of dealing with feelings, thoughts, and behavior it may feel worse before it gets better. If I believe I am in crisis, I will contact my clinician or designee, or go to my nearest hospital emergency room for evaluation.

II. Confidentiality

a. I understand that my insurance company or other payment source for my treatment require diagnostic and treatment planning information in order to pay for services rendered. In addition, I understand that it is generally desirable for my clinician to provide clinical information to other professionals I am involved with to coordinate care. **INITIALS**

b. The office will not release any information without my knowledge and consent, except in the following circumstances, as applicable:

1. In the event of a subpoena, or if a judicial system mandates the release of records.
2. When clinicians have information indicating that a child under age 18 or adult over age 65 is (or has been depending on jurisdictions) abused or neglected, the clinician is a mandated reporter and legally required to report to child/adult protective services.
3. If I am a danger to myself or others, my clinician will do whatever is ethical to protect me or others. This may include hospital admission, notification of emergency contacts, relatives, and/or police. I also understand that my clinician has a duty to warn individuals identified who are at risk to be harmed.

III. Communication Outside of Session

a. Texting and email communication are not confidential and are not meant to be therapeutic methods of communication, but can be useful for scheduling purposes. **INITIALS**

b. Please check below to authorize the following methods of communication:

☐ Email ☐ Cell Phone ☐ Text Other: _____

Please note that billing statements will be sent through the mail if you accrue an outstanding balance

IV. Clinician Consultation and Supervision

a. CCCC clinicians often consult with each other when they may benefit from clinical support and feedback from colleagues at CCCC, or when working with the same clients (e.g. couples, DBT referrals, family, etc.). CCCC clinicians will only share information that benefits the client(s), and the client and clinician have agreed upon the information that will be shared. **INITIALS**

b. Some of our clinicians are under clinical supervision and will share client information with their supervisors. Clients will be informed of this when they first meet with the clinician.

V. Scheduling and Fees

a. Payment is expected at the time services are rendered and paid before my sessions begin. This includes co-pays, deductibles, self-pay fees, etc. **INITIALS**

b. I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I am also responsible for services not covered or denied by my insurance company, such as, but not limited to: psycho-educational services, workshops, paperwork for school or work, letters, and legal matters. The clinician will inform me of the time and cost of the non-covered services and make arrangement with you for payment. Costs for services not covered by insurance are my responsibility, including payments expected from my insurance carrier which have been denied. Payments not made at the time of service are subject to a 1.5% fee increase every 30 days of non-payment and will be sent to collections after 90 days unless a payment agreement is adhered to.

c. Appointments are scheduled through administrative staff in collaboration with clinicians. If I need an emergency appointment, I will contact the office or instructions given by my clinician.

d. Services beyond those covered by my insurance company are provided on a self-pay basis, workman's compensation, or other agreed upon payment source.

VI. Missed Appointments

a. There is a charge of **$100.00** for missed appointments or late cancellations. We require a 48-business hour notification to avoid this fee (calls must be placed during business hours, and Tuesday cancellations need to be called by Saturday). Medicaid clients and Military personnel are not subject to this fee. **INITIALS**

VII. Attendance Policy

a. The practice's policy around late cancellations and no shows is as follows: after 3 late cancellations or no shows, clients can lose their standing appointment on their clinician's schedule; 3 more after that and they can lose their ability to stay in the CCCC practice. Clinicians have discretion regarding how and in what way they manage this expectation. **INITIALS**

VIII. Reasons for Non-Compliance Terminations

a. My clinician may terminate treatment at CCCC under the following circumstances: **INITIALS**

1. Failure to comply with the treatment plan/recommendations by the clinician.
2. Failure to maintain my financial responsibilities.
3. Several cancellations or no shows for scheduled appointments.

IX. Couples, Family, Group Psychotherapy

a. I will keep information revealed by others confidential. **INITIALS**

b. Group clinicians may have a separate consent form for their specific group.

c. Medical records from couples therapy cannot be released without both parties' consent.

I, _____ have read and understand the various aspects of psychotherapy
(name of patient or parent of minor child)

such as evaluation and method of treatment for myself or my child, _____ .
(name of minor child, if applicable)

Please Sign Below and Go Over This Form with Your Clinician at your First Session

_____

Patient/ Parent/Legal Guardian's Name Signature Date

_____

Other Participants Name Signature Date

_____

Clinician Name Signature Date

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I _____ _____ _____ _____
(Member Name) (Insurance Name) (Policy Number) (Date of Birth)

authorize _____ , to release protected health information related to my evaluation and treatment to
(Provider Name - Please Print)

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____ _____ _____ _____
(Street Number, Street Name, Building & Suite Number) (City) (State) (Zip Code)

Information Below to be Completed by Behavioral Health Provider

I saw _____ **on** _____ **for** _____
(Patient Name - Please Print) (Date(s) of Service) (Reason or Diagnosis)

Summary:_____

_____

The following medication was or will be started:_____
(indicate medication name and dosage/frequency)

If no medication is indicated, check the following as appropriate:

☐ Medication Not Prescribed ☐ Patient Refused Medication ☐ Try Psychotherapy Before Trying Medication

Treatment Recommendations:

Lab Tests for the Following: ☐ CBC ☐ Thyroid Studies ☐ Chemistry Panel ☐ EKG

Other Treatment Recommendations: _____

_____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____
(Phone Number)

_____ _____ _____
(Provider Signature) (Provider Printed Name) (Licensure)

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: _____ .
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on the date specified below, within one (1) year or less from the date of signature. I have read and understand the above information and give my authorization: **PATIENT PLEASE CHECK ONE**

☐ To release any applicable mental health / substance abuse information to my primary care physician.
☐ To release only medication information to my primary care physician.
☐ To release the date of my first visit following my hospitalization from _____ through _____ to my primary care physician.
☐ I DO NOT give my authorization to release any information to my primary care physician.

_____ _____ _____ _____ _____
(Patient Signature) (Date) (Expiration Date) (Signature of Patient's Authorized Rep.) (Date)

IF SIGNED BY PATIENT'S AUTHORIZED REPRESENTATIVE, DESCRIBE RELATIONSHIP TO PATIENT: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PCP AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Patient Information Release Authorization-Under 18
Communication and/or Records

Patient Name	Date of Birth	Social Security Number

I hereby authorize the following individuals to have access to my child's information and medical records, including any parent or family members that are not present at the initial session that you would like to have access.

First and Last Name	Phone number/email

The information may include the diagnosis and records of any treatment or examination rendered to my child during the period of _____ to _____.

The parent/guardian may end this authorization at any time in writing.

_____

Printed Name of Patient (Parent or Guardian if minor child) Signature Date

_____

Clinician Name Clinician Signature Date

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Telehealth Informed Consent

Client Name: _____Clinician: _____

(Other Participants) _____

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio-video communication. I hereby consent to participating in psychotherapy via audio-video communication (referred to as telehealth below).

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS UNDER THIS AGREEMENT:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. My clinician and I will establish an emergency plan and protocol for contact in between sessions. This will be established before the start of treatment, and I can request a copy of these protocols in writing. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, it may be recommended that I come into the office for sessions.

CCCC clinicians use Zoom to conduct telehealth sessions, in addition to our electronic health records system, Valant. Clinicians do not download any client PHI (personal health information) onto their computers, and are trained and up-to-date in HIPAA compliance. All client records are stored in Valant and comply with the highest HIPAA standards. In order to use Zoom, CCCC must have an accurate email address for you on file. Please be sure to include that at the end of this form.

I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I am also responsible for services not covered or denied by my insurance company. It is recommended that I call my insurance company to confirm in writing that they will cover telehealth therapy. My clinician will inform me of the time and cost of the non-covered services and make arrangement

with me for payment. Costs for services not covered by insurance are my responsibility, including payments expected from my insurance carrier which have been denied. Payments not made at the time of service are subject to a 1.5% fee increase every 30 days of non-payment and will be sent to collections after 90 days unless a payment agreement is adhered to.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to CCCC, LLC. My signature below indicates that I have read this Agreement and agree to its terms.

Email for Zoom: _____

Best phone number for billing purposes:_____

(Other Participants) Email Address: *(Other Participants)* Phone Number:

_____ _____

I can also leave a credit card number on file for billing purposes:

CREDIT CARD NUMBER: __ __ __ __--__ __ __ __--__ __ __ __-- __ __ __ __

EXP. DATE: __ __ / __ __ CVC:_____ ZIP CODE:_____

NAME ON CARD: _____ _____ _____
(FIRST) (M) (LAST)

_____ _____
Client Signature Date

_____ _____
Other Participants Signature Date