HeartLife
professional soul care

Registration & Information

Name ____ Age _____ Sex _____ Marital Status ______

Date of Birth ____________________ Email Address ____

Home Address ____ Cell Phone __________________________

City ____ State ______________ Zip ______________

Work Address ____ Work Phone _________________________

City ____ State ______________ Zip ______________

Responsible Party (if other than client) __________________________ Relationship to Client _______________

Who referred you to us? __________________________________ Date problems first noted _______________

Date(s) of any previous therapy/treatment: ____

Who provided the previous treatment? ____

Primary care physician _______________________________ Contact information: _______________________

Primary Care Physician's Address ____

When was your last comprehensive medical evaluation? ____

Please list any medications you are currently taking: ____

Any additional information you'd like our staff to know: ____

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Welcome to HeartLife Professional Soul Care

Please read this document carefully as it contains important information about HeartLife. Once you sign this document it will constitute a binding agreement between us, as well as give us your consent to begin therapy.

Counseling Services

HeartLife clinicians offer in-person sessions and virtual sessions since the advent of the Covid pandemic. We offer services including therapy for individuals, couples, and families. "Therapy" or "counseling" is often difficult to describe. HeartLife offers biblically informed counseling. It is important for you to understand that we are licensed * professionals striving for clinical excellence. If there are any questions about our approach, please ask your therapist during your first session. We also offer psychological and educational testing. **Licensed and/or under the direct supervision of an approved supervisor.*

As therapists we cannot provide any medications or perform any medical treatments. However, if medication seems indicated, we maintain close working relationships with many local physicians and psychiatrists, and we will gladly refer you to these practitioners.

One potential benefit of therapy is the ability to detect, challenge, and change those beliefs and attitudes that create, maintain, and worsen conditions such as depression, anxiety, panic, anger, frustration, etc. Christ-centered therapy can help us gain new understanding about our problems and learn new ways of applying God's Truth to our lives. Sometimes there are potential risks when entering any therapeutic relationship. In certain situations, people may experience some degree of discomfort, feelings of sadness, anxiety, frustration, etc., when working through difficult issues. Some may recall unpleasant aspects of their life and at times, report feeling worse before feeling better. Our desire is for people to be strengthened individually as well as in their relationships with others. We will regularly review with you your goals and progress. We value your honesty in providing input or suggestions. At any time during our work together, you have the right to decide to end treatment, and there is no moral, legal, or financial obligation other than to pay for the services already rendered. If you are thinking about ending therapy, we encourage you to discuss this with us and, if you wish, we will provide you with the names of other mental health providers.

Communication with your Therapist and Sessions

Our sessions are 50 minutes, although extended appointments are available. We also offer scheduled phone and virtual sessions with established clients and patients who are a good fit for this option. These sessions will be charged at each of our therapist's normal session rate. It is important to mention that non-scheduled phone calls are not the best way in which to deal with therapy issues. HeartLife office staff will not give out clinician's email addresses due to ethical and legal concerns. Should your therapist determine to email you regarding scheduling etc., they can do so at their discretion. Please be advised that while our servers are secure, we cannot guarantee confidentiality of any information exchanged via email. Our therapists are not interrupted during sessions for incoming calls unless it is an emergency. In the event of a life-threatening emergency, it will be necessary for you to call 911.

Cancellation Policy

Unless 24 hours' notice is given Monday through Friday, you will be expected to pay for the missed appointment (full session charge) unless the Administrator excuses payment due to circumstances beyond your control. Circumstances beyond your control may include illness, family emergency, and severe weather. In the event of this type of situation it is important to reach out to our front desk as soon as possible to speak with our staff about the late cancellation including the reason for the late cancel. Our office needs this notice to fill any vacant appointment times with other clients on a waiting list. In the event of extremely bad weather such as ice and snow, is it advisable to call to make sure the office is open. Please understand that cancellations on the weekend, or holidays do not fall in the 24-hour period as our office is closed and our staff is unable to fill your cancelled slot. The Administrator may discuss your cancellation with your counselor, but the final decision will be determined by our Administrator. *By initialing here, I agree to the cancellation policy as written above ______ (initials).*

Professional Fees and Payments

Please check with our front desk staff for our current session fees. You will be expected to pay for each session at the time of the session. Please remember that our office does not file insurance claims. Should you decide to file, we can often provide you with the necessary information however, we cannot communicate directly with your insurance company. All fees are subject to change, and in the event of fee changes, you will be notified as least 30 days in advance. There is a $25.00 service charge on all returned checks. *By initialing here, I am agreeing to pay at the time each session is held* ____(*initials)*
By initialing here, I am indicating that I understand that HeartLife does not participate in managed care contracts ______*(initials).*

Additional Information

Please remember that we have a professional relationship with you and not with your insurance provider. Fees are charged to the client, and we cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for your bill regardless of the action of your insurance provider.

The escalation of the cost of health care has resulted in an increasing complexity of insurance benefits which often makes it difficult to determine exactly how much mental health coverage is available. Additionally, "managed health care plans" such as PPOs and HMOs often require advance authorization before they will provide reimbursement for mental health services. Many such plans emphasize "brief" or "short-term" therapy. If you choose to use a provider who is a member of your MCO, be advised that they may not counsel from a biblical or Christian perspective.

Insurance providers and managed care companies almost typically require outpatient treatment plans or reports as a condition for certifying or re-certifying treatment. Information requested may be as simple as a diagnosis and type of treatment or may also be of a personal nature requiring more detailed information including the entire record. This information will become part of the insurance provider's electronic record. All insurance providers/managed care companies claim to keep such information with a national medical information data bank (such as the MIB – Medical Information Bureau). Due to the potential for loss of privacy, some clients prefer not to file insurance claims.

Legal Involvement

It is important to note that HeartLife professionals work toward relational reconciliation, because of this our registration forms require your signature indicating you will not depose our staff in the event of legal proceedings. Should this agreement be ignored, and we become involved in any legal matter via court order or deposition, our standard fee is $150 per hour to review case files, talk with clients/patients, or attorneys in addition to the fee of $1000 detailed below. Should we be deposed or ordered to testify, a fee of no less than $1000 (some clinicians will charge more) is required for testimony or deposition per day.

Special Note: Because of our Christian perspective, we encourage reconciliation when relationships are damaged. When a family is confronted by parental separation or divorce, it creates difficulties for every member of the family. When working as a couple it is of paramount importance that both parties feel safe to speak honestly and without the fear that treatment issues addressed in therapy will be used litigiously. It is important that you agree not to call your counselor as a witness nor attempt to subpoena counseling records. *My initials indicate I agree to comply ________(initials).*

Confidentiality

Within the limitations discussed below, the information you reveal to your counselor during the professional relationship will be kept confidential and will not be released to anyone without your written consent. No clinical or counseling information is revealed to our staff other than information that you provide when calling or presenting for appointments. We have discussed the legal and professional necessity of confidentiality with our staff. However, certain conditions do require that confidentiality and privileged communication be breached including:

(1) if you present a danger to yourself

(2) if you present an imminent danger to another person, which can include a communicable disease that can be life-threatening to others

(3) if there is reason to believe that child abuse or neglect is present or has been present, a report must be filed with a state child protection agency (elder abuse applies as well)

(4) if a legitimate court order is issued

(5) if the treatment is ordered or under the supervision of the court

(6) If an insurance provider or managed care organization requires a release of information for potential reimbursement it is important to note that we are not in any way responsible for the mistreatment of your information by these entities. Further, we will not be responsible for injuries or claims of damages that could result from releasing your information to any third party.

7) Nonpayment of an outstanding balance will result in a release of the most minimal amount of information necessary to settle the balance. Information revealed in marital therapy is protected by privileged communication in Tennessee and requires permission of both parties to waive. When working with couples, we adopt a "no secrets" rule. That is, should your counselor speak individually

with either party, he or she reserves the right to disclose any information to the other party if he or she believes such information is relevant to the therapy process.

In order to provide coverage when your therapist is out of town or ill, it may be necessary for them to release general information to the licensed counselor covering or one of our directors.
By initialing here, I am indicating that I understand and agree that my therapist may share information regarding my case for consultation and oversight ________ (*initials*).

Agreement

I have read this information fully and completely, I have discussed any questions I have about the information, I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy. I have familiarized myself with the fees and charges for services provided by HeartLife Professional Soul Care and I understand and agree that the counseling services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of services, and I understand I am responsible for all costs of collection and litigation, including attorney's fees. If I consent and agree that HeartLife Professional Soul Care may release information, as requested by me, to my insurance company and/or managed care company for services rendered, I agree to hold HeartLife Professional Soul Care harmless for any injury or claim for damages arising from release of records or information as I request to my insurance company or managed care company.

Client ____ Date ____________

Responsible Party/Guardian ____ Date ____________

Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new client/patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client/patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client/patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care; and providers and health care agencies throughout the country are now required to provide clients/patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and often difficult to grasp if you don't have formal legal training. Our Client/Patient Notice of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document since it is important you know what client/patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, we will do all we reasonably can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have reviewed this Client/Patient Notification of Privacy Rights Document, and have been offered a copy of the document, if you so desire. Thank you for your thoughtful consideration of these matters.

I, ____________________________________, understand and have reviewed a copy of
HeartLife Professional Soul-Care's Notice of Privacy Practices (NPP) which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form, and that a copy of this document is also available upon request.

____ ________________

Client/Patient Signature Date