Nathan Kerr, LPC
Professional Counseling Services

CLIENT REGISTRATION INFORMATION

Today's Date: _____

Client Name: _____
Last First MI

DOB: _____/_____/_____ Sex:_____ Age:_____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Telephone: Home (_____)_____ Work (_____)_____Cell (____)_____

Email:_____ May I leave messages for you at home?_____ work?_____

Social Security #:_____-_____-_____ Marital Status: _____

Employer:_____ Employer Address:_____

Student: Full-time_____ Part-time_____ School:_____

Permanent Address, if student: _____

City:_____ State:_____ Zip:_____

Telephone: Home (_____)_____

Person Responsible for Bill :(if patient is a minor)_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact: _____ Relationship:_____

Telephone: Home (_____)_____ Work (_____)_____ Cell (____)_____

Primary Insurance Company:_____

Company Address:_____Telephone: (_____)_____

Under what name is the insurance policy?_____

Insured's Social Security #:_____-_____-_____ Insured's DOB:_____/_____/_____

Insured's Address:_____

Insured's Telephone: Home (_____)_____ Work (_____)_____

Insured's Employer:_____

Policy / group number:_____ Member number:_____

Insured's co-payment percentage / amount: _____

Has deductible been met for this client? Yes No

Limits on insurance for this type of benefit:_____

Secondary Insurance Company:_____

Company Address:_____Telephone: (_____)_____

Under what name is the insurance policy?_____

Insured's Social Security #:_____-_____-_____ Insured's DOB:_____/_____/_____

Telephone: (_____)_____ ID #: _____ Group policy? Yes No

Insured's Address:_____

Insured's Telephone: Home (_____)_____ Work (_____)_____

Insured's Employer:_____

Policy / group number:_____ Member number:_____

Please have responsible party read and sign below

Statement of Responsibility

I have read the **CONTRACT FOR COUNSELING SERVICES** and agree to its terms and I also acknowledge that I received the ***"Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information"*** described in the agreement. I understand that I am financially responsible for all charges made to me by my therapist, even though I have insurance that may pay part of all of my incurred charges. **I understand that I will be billed for any appointments not cancelled with 24 hours notice.**

Signature_____ Date:_____
(Client or parent/guardian)

Assignment of Benefits

I hereby assign any and all rights or payments which may be due or payable to me under policy number _____ with _____ insurance company. This assignment is made in behalf and directly to Nathan Kerr, LPC, I authorize the release of any psychotherapeutic information necessary to process my claims. If any current policy prohibits direct payment to the named company, I hereby instruct my insurance company to make out the check to me and mail it as follows:

Nathan Kerr, M.A., LPC
265 West Pike St. Suite #4
Lawrenceville GA 30043

Insurance Verification Waiver

I authorize Nathan Kerr,LPC to communicate with my employer's insurance representative, my insurance company, or their designated verification individual for the purpose of verifying coverage of my insurance policy. I also authorize Nathan Kerr, LPC, to file complaints to the insurance commissioner in my behalf.

Signature_____ Date:_____
(Client or parent/guardian)

Nathan Kerr, LPC
Professional Counseling Services

Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information

We have a duty to protect the confidentiality of information about you. We are required to provide you with a Notice of Privacy Practices explaining the ways we may use and disclose your information. ***Nathan Kerr, LPC*** will the follow the Notice. It will be followed by any professionals and staff affiliated with ***Nathan Kerr, LPC***.

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

I may use or disclose your protected health information (PHI) for treatment, payment, and healthcare operations purposes with your consent. To help clarify what this means, explanations are provided.

Specific Examples Include:

- Emergency treatment
- Appointment reminders
- Auditing
- Worker's Compensation
- Lawsuits and disputes
- Managed Care Networks
- Payment/Reimbursement
- Protection against serious threat
- As required by law

Uses and Disclosures Requiring Authorization

I may use or disclose PHI when your appropriate authorization is obtained. For instances outside of treatment, payment, and healthcare operation, your authorization will be requested. Your "authorization" is your written permission for specific contact or transfer of information to occur with a specified individual/agency. I will request your authorization before releasing information including psychotherapy notes or evaluations. Psychotherapy notes are notes that I have made from our sessions or conversations that are not a part of your medical record. These notes have a greater degree of protection than your PHI.

You are able to give your authorization and you are able to revoke all authorizations at any given time. Revocation for each authorization must be given in writing. You cannot revoke authorization if the authorization has been relied upon for treatment or if was necessary as a condition to obtain insurance coverage.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose your PHI without your consent or authorization in the following situations:

- **Child Abuse:** Reasonable cause to suspect a child is being abused will lead to a mandatory report to the appropriate authorities.
- **Adult and Domestic Abuse:** Reasonable cause to suspect a disabled adult or elderly person is being abused, has been neglected, or exploited will lead to a mandatory report to the appropriate authorities.
- **Judicial and Administrative Proceeding:** If you are involved in a court proceeding and a request is made about your professional services received, such information is privileged under state law, and will not be released without written consent or a court order. However, this privilege does not apply if you are being evaluated by a third party or where an evaluation is court ordered. You will be informed in advance if this is to be the case.
- **Serious Threat to Health or Safety:** If I determine that you present a serious danger of violence to yourself or another person, I may disclose information in order to provide protection against such danger to yourself or the intended victim.
- **Worker's Compensation:** I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

<u>Patient's Rights and Therapist's Duties</u>

Patient Rights:

- The right to request confidential communication by alternative means and at alternative locations.
- The right to request restrictions on certain uses of your information. However, I am not required to agree to a restriction that you request.
- The right to inspect and to copy certain information of PHI in my medical or billing records. I may deny your access under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- The right to request an amendment of your information for as long as it is maintained in your record. I may deny your request. Upon your request, I will discuss with you the amendment process.
- The right to an accounting of certain disclosures of your PHI. On your request, I will discuss with you the details of the accounting process.
- The right to paper copy of the notice from me upon request even if you agreed to receive a notice electronically.
- The right to have a copy of this notice, and to choose someone to act for you.

Therapists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will make this information available either by mail or by request for a review of this information.

Complaints

If you believe your rights have been violated, or you disagree with a decision I made about access to your records you may contact either of the partners in this practice. We encourage you to speak to us about your healthcare concerns. You may file a written complaint to the Secretary of the US Department of Health and Human Services. This address can be provided to you upon request.

I, the undersigned, acknowledge that I have received, read, and understand the ***"Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information"*** from ***Nathan Kerr, LPC Professional Counseling Services***. This policy is required by law under Health Insurance Portability and Accountability Act (HIPAA).

_____

Signature of Client or Parent/Guardian Date

_____

Name of Client or Parent/Guardian (Please Print) Date

_____

Signature of Other Adult Party Date

_____

Name of Other Adult Party (Please Print) Date

_____

Name of Client if under 18 years of age Date

_____

Signature of Treating Therapist Date

Nathan Kerr, M.A., LPC
265 West Pike Street, Suite 4, Lawrenceville, GA 30045
(404) 314-6168 Fax (678) 407-4444

CONSENT FORM FOR EXCHANGE/RELEASE OF INFORMATION

PATIENT NAME:
_____

DATE OF BIRTH:
_____SSN:_____

LEGAL GUARDIAN IF PATIENT IS A MINOR:
_____

I, _____, give my permission to Nathan Kerr, M.A., LPC
his staff and the person (s) listed below to exchange information and/or records regarding myself or my dependents. I give permission for a faxed or photocopied signature to serve as an original regarding this release. The purpose of this release is to share/release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be subject to revoke by the individual signing this consent by providing a written, signed and dated request to withdrawn the authorization except to the extent that action has already been taken.

1._____

2._____

3._____

4._____

_____
Signature of Client Date signed

_____ _____
Witness Signature of parent/ guardian

Nathan Kerr, LPC
Professional Counseling Services

Nathan Kerr, M.A., LPC

Contract for Counseling Services

Welcome to our private practice. We appreciate the opportunity to work with you. Before getting started, we would like to familiarize you with the policies of our practice. Please read this information carefully and feel free to discuss any questions or concerns with your therapist at any time. When you sign this document, it will represent a contract between you and your therapist.

The first few sessions will focus on information gathering and getting acquainted. This time allows your therapist to learn more about you and your concerns, goals, hopes, and expectations, while allowing you to learn more about their way of working within the psychotherapy relationship. At the end of this initial evaluation, you and your therapist will jointly plan a course of therapy to meet your needs.

Appointments and Cancellations

Initial evaluations usually last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Therapy sessions last 45-50 minutes (one appointment hour of 45-50 minutes duration) and are typically scheduled on a weekly basis, although some sessions may be longer or more frequent. If you cancel or reschedule an appointment, please give 24 hours notice in order to avoid being charged for that hour.

Fees and Payment

The initial intake session is a fee of $150. Following that, the hourly fee is $120 for each 45-50 minute individual session, and $150 for family & couple sessions. Fees are payable in full at the time of each session. Sliding scale rates are available for those in need of financial assistance. You may pay in cash, check, or by credit card. There is a returned check fee of $ 50.00 per check. Collection services are utilized for delinquent accounts and related charges will be applied to the balance due.

Use of Insurance

We currently accept insurance panels. Insurance co-payments are due at the time of service. If we are an out-of-network provider and you wish to seek reimbursement from your insurance company, documentation will be provided to assist you with this process.

Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate. We can provide an Insurance and Benefits Information form to help you obtain this information.

We will submit the appropriate bills to your insurance company one time and try to remedy any denial or payment problem related to billing one time. If after these billing attempts, the insurance company refuses to pay the bill, it will become your (the

client's/guardian's) responsibility to work with the insurance company to obtain appropriate reimbursement.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes your therapist will have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, your therapist has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. A copy of any report submitted is available upon request.

If you or your child is covered by a secondary insurance plan, we will be happy to provide you with appropriate billing forms which you can submit to your secondary insurance company. We will ask that you be responsible for payment of the portion of services not covered by your primary plan and that you seek reimbursement from the secondary plan for yourself.

Occasionally, services other than psychotherapy time are needed or requested (e.g., treatment reports, letters, extended telephone conversations, etc.). Such services, as well as associated out-of-pocket expenses, will be charged to your account. The hourly fee will apply, and will be pro-rated for portions of an hour if appropriate. If you enter into legal proceedings that require your therapist's participation, they will bill for all professional time (including preparation time and travel time) even if required to testify by another party. Because of the complexity and time involved in legal matters, the fee for such service is $__120_ per hour.

Contacting Your Therapist

Your therapist may not be immediately available by telephone. When he/she is unavailable, their telephone is answered by a confidential voice mail that they monitor frequently. They will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. Please inform him/her of times when you will be available. If you are unable to reach your therapist and are experiencing a life threatening emergency, contact 911 or the nearest emergency room. If your therapist will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary.

Confidentiality

In general, the privacy of all communications between a patient and a therapist is protected by law, and your therapist can only release information about your work to others with your written permission. However, there are a few exceptions. If your therapist has reason to believe that a child, elderly person, or disabled person is being abused, they must file a report with the appropriate state agency. If your therapist becomes aware of an immediate threat of harm to a particular individual, they would be required to take protective actions that might include notifying the potential victim, contacting the police, contacting family members, or seeking hospitalization. If a patient threatens to harm himself/herself, your therapist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, your therapist will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment. In some proceedings, such as those involving child custody and those in which your emotional condition is an important issue, a judge may order your therapist to testify if he/she determines that the issues demand it. Alternatively, if you asserted that you had suffered mental or emotional damage in a lawsuit, such records might be necessary to prove your claim. Under any of these circumstances, your therapist would discuss the situation with you prior to providing any information about you and would protect your privacy to the greatest extent possible under the law.

FOR COUPLES:

Conceivably, one of you might someday think that your therapist's testimony would be helpful to you in a legal proceeding, such as a divorce. Please remember, that the therapist's testimony would require written releases from both of you.

Your therapist may also occasionally find it helpful or even necessary to consult other professionals about a case. During a consultation, every effort will be made to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. If you do not object, you will not be told about these consultations unless your therapist feels it is important to your work together.

The laws and standards of the psychological profession require that treatment records be kept. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you. However, since these are professional records, they can be misinterpreted to untrained readers. If you wish to see your records (or your child's records), we recommend that you review them in your therapist's presence so that they can discuss the contents with you. Patients will be charged our hourly fee for any professional time spent in responding to information requests.

Finally, records can be released to a third party with your written consent. This might include, for example, release of information to another treatment provider or to an insurance carrier per your request. Please note, however, that your therapist cannot be responsible for the confidentiality or disposition of records released to a third party once in the hands of that third party.

Professional Records

The laws and standards of our profession require that we keep treatment records regarding your work with your therapist. You are entitled to receive a copy of the records unless your therapist believes that seeing them would be emotionally damaging, in which case your therapist will be happy to send them to another mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. As such, if access to the records is determined to be non-harmful, records will be reviewed with your therapist so that you can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests. A request to review records must be received in writing.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, your therapist will provide them only with general information about your work together, unless he/she feels there is a high risk that you will seriously harm yourself or someone else. In this case, your therapist will notify them of his/her concern. Before giving them any information, your therapist will discuss the matter with you, if possible,

and do their best to handle any objections you may have with what they are prepared to discuss.

Informed Consent

I _____ (name of client) agree and consent to participate in behavioral health care services offered and provided at/by **Nathan Kerr, M.A., LPC** a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the client. If the client is under the age of eighteen or unable to consent to treatment. I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Consent

Your signature below indicates that you have read the information in **The Contract for Counseling Services** and agree to abide by its terms during your professional relationship.

_____

Signature of Client or Parent/Guardian Date

_____

Name of Client or Parent/Guardian (Please Print) Date

_____

Signature of Other Adult Party Date

_____

Name of Other Adult Party (Please Print) Date

_____

Name of Client if under 18 years of age Date

_____

Signature of Therapist Date

Nathan Kerr, LPC
Professional Counseling Services

CREDIT CARD AUTHORIZATION

I authorize Nathan Kerr, M.A. LPC to charge my credit card for services rendered, no show fees, and late cancellation fees. This information is stored in a locked file cabinet and will be shredded upon termination of counseling and balance is paid in full.

Client's Name: _____

Cardholder's Name: _____
(print name)

Cardholder's Address: _____

_____

Credit Card: _____ Visa _____ Master Card _____ Discover _____ Am-Ex.

Credit Card #: _____

Expiration Date: _____ Security Code (3-digit # on back of card):_____

Cardholder's Signature: _____

Date: _____

HSA/FSA Card Information

*****_We are happy to attempt to use your HSA/FSA Card for your co-pays. However a regular credit card must also provided in the event that your HSA does not allow us to run the charge or you have a no-show /late cancellation fee_.

HAS/FSA Card: _____ Visa _____ Master Card _____ Discover _____ Am-Ex.

Credit Card #: _____

Expiration Date: _____

Security Code (3-digit # on back of card): _____

Cardholder's Signature: _____

Date: _____

Nathan Kerr, LPC
Professional Counseling Services

Communication through Email, Text or Internet

Nathan Kerr, LPC is able to provide communication with our clients through all the current electronic methods. However, it is important that you as our client understand that **confidentiality can not be assumed or provided** with any information that you share through email, text or the internet. We will make every effort to keep your information private, however we can not guarantee information you share with us electronically can be kept confidential. Please keep this in mind when sharing problems, concerns or information with us through these electronic methods.

If you choose to communicate with Nathan Kerr, LPC Therapy by email, be aware that all emails may be retained in the logs of your Internet service provider and our Internet service provider. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact your therapist between sessions, the best way to do so is by phone.

Please do not engage with Changing Perception therapists in public online if we have an already established client/therapist relationship. We do not accept friend or contact requests from current or former clients on any social networking site like LinkedIn. We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your therapist and we can talk more about it.

I have read and understand the limits of confidentiality regarding electronic/digital communications.

Signature Date

Nathan Kerr, LPC
Professional Counseling Services

LATE CANCELLATION AND MISSED APPOINTMENT POLICY

Once you schedule an appointment with a Nathan Kerr, LPC, that time is reserved exclusively for you. In order to successfully operate our clinical practice, we rely on these therapy appointments. Therefore, we have established the following policy for missed and late-cancellation appointments.

A) For any appointment that is missed or canceled with less than the required 24 hour notice, clients will be charged the missed appointment/late cancellation fee.

B) The missed appointment fee is **$120** for Individuals, **$150** for couples/families.

C) A credit card information form must be provided and will be kept in a locked file cabinet. At the time of the missed appointment/late cancellation, your card will be charged the missed appointment fee stated above.

D) Missed appointment fees are not covered by insurance, and the **fees are not the same as your copay.** Insurance can not be billed when you do not come for your appointment.

E) The only exceptions are: situations that require immediate medical attention, funerals, and deaths in the family. There is no charge in these circumstances. However, there are other circumstances that do result in a charge, even though you had no control over them. These include last-minute business meetings, car breakdowns, minor illnesses, babysitters who don't show up, airplanes that don't fly on time, and similar difficulties.

I have read the above information and have been informed of the policies and procedures above.

Signature:_____ **Date:**_____