Please provide your photo ID and insurance card for us to copy.

Group: DJLS Therapy Services, LLC
Provider Name: _____

PLEASE PRINT

NEW Patient Registration Information

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	Age	SEX	SSN, *last 6 digits are acceptable*
		☐Male ☐Female	

MARITAL STATUS

☐Single, never married ☐Married, living together ☐Married, not living together ☐Cohabiting with Partner
☐Separated ☐Divorced ☐Widowed ☐Other, explain:

EMPLOYMENT/STUDENT STATUS *(check on from each category, if applicable)*

Employment Status	Student Status
☐Unemployed, not looking for work ☐Unemployed, looking for work ☐FT employed ☐ PT employed ☐Retired ☐ Self-Employed ☐On Welfare ☐Soc Sec Disability	☐Part-Time ☐Full-Time ☐Not a student

Employer Name, if employed:	

HOME ADDRESS

House Number and Street Address (apt #, if applicable)	City, State & Zip code

CONTACT INFORMATION

Home Phone	**Work Phone**	**Cell Phone**

Email(s)	Preferred Method of Communication
1)	☐ Home Phone ☐Work Phone ☐Cell Phone
2)	I agree to receive appt reminders via cell? ☐Yes ☐No I agree to rec. balance reminders via cell? ☐Yes ☐No

Please give us your insurance card(s)to copy for our records

INSURANCE INFORMATION ***if not using insurance, skip to responsible party section***

Insurance Company Name	Policy Number	Group Number

If using an EAP (Employee Assistance Plan), Please indicate the EAP info	EAP Carrier Name:	# of Approved EAP Visits:	EAP Start and End Dates:
	EAP Approval Code:		

RESPONSIBLE PARTY ☐Same as Patient

This Is the person that is responsible for any unpaid balances (copays, coinsurance and/or deductibles)

Name:		Relationship to Patient: ☐Mother ☐Father ☐Guardian ☐Other, explain
DOB:	SS#	Address ☐*ck here if same as patient*

Authorization and Assignment:

I authorize the release of medical information necessary to process this and all claims to my insurance company, including Medicare and Medicaid. I request benefits be made payable to _____. I acknowledge that I am financially responsible for this and all claims whether or not paid or covered by my insurance company or other organization. I also agree that if my account is referred to a third party for 90 days past due, I will be responsible for the collection agency fee of 35% plus the balance due and interest.

_____ _____

Signature of Patient *(Parent or Gurdian if minor child)* Date

DJLS Therapy Services, LLC
14300 Gallant Fox Lane
Suite 115
Bowie, MD 20715
571 236 7012

General Information and Informed Consent

Please read this informed consent carefully, and be sure you have understood it. We encourage you to discuss any questions with DJLS Therapy Services.

Who We Are

We are licensed independent clinical social workers and licensed Clinical Professional Counselors and are licensed to practice psychotherapy in Maryland. We adhere ethical principles and standards of practice. We offer psychotherapy for individuals, couples and families at DJLS Therapy Services located at 14300 Gallant Fox Lane Suite 115 Bowie, MD 20715.

What to Expect

We will collaborate to decide what will be most helpful for you. Open and honest discussion of your experience will make therapy most effective and useful for you. Sessions are 60 minutes in length and sessions take place weekly unless we agree on another arrangement.

Therapy takes time and it will take time to see positive changes. Therapy will make you more aware of your feelings, and this could lead to increased distress. We encourage you to share your reactions, questions, and concerns at your therapy sessions so we can help you process your feelings.

We will set treatment goals during your therapy visits. Periodically, we will review your goals to determine progress. When you are ready to terminate therapy, it is important that we review the work that we have done together, regardless of how long you have been in treatment. This will allow you to terminate therapy with appropriate closure and continue progression of your treatment goals.

Appointments

If you are not able to keep an appointment, we ask that you please provide 24 hours notice. If you are not able to cancel within 24 hours, you will automatically be charged 100.00 for a missed session. This fee is not payable by the insurance company and will be charged to your credit card on file. Clients will be responsible for co-pays, late cancellation, no show fees, coinsurance, and deductibles when applicable.

Session Fees

We participate with multiple insurance plans. You will be responsible for your co-pay. Payment is due at each visit by cash or debit/credit. In the event that your insurance claim is denied you will be billed for services. For those who are self pay, session fees are $150.00 per 60 minute session for psychotherapy to include (Family, Individual, and Couples). If needed, we will provide a detailed receipt for you to file for reimbursement with your insurance plan.

If you are insured and have a deductible beyond your ability to pay for your session the minimum that DJLS Therapy Services LLC will collect for your therapy session is 100.00. We are unfortunately unable to negotiate a lower rate with you and would not be able to provide you therapy services until your deductible is met.

Forms and Letters

DJLS Therapy Services LLC is happy to complete forms or write letters on your behalf. We charge a one-time fee of $30.00 per calendar year for this service.

Use of electronic communication with e-mail and text messaging

DJLS Therapy Services will use these methods to communicate about non-sensitive and non-urgent issues. All communications to or from you may be made part of your medical record. You have the right to access such communications as you do to the remainder of your medical record. Your e-mail or text messaging may be forwarded to another employee or contractor of DJLS Therapy Services as necessary as part of your care. E-mail and text messaging may also be used to schedule an appointment, remind you of an appointment, or to change an appointment.

If you would like to opt out of electronic communication please check either 1, 2, or 3 otherwise check option 4 if you agree.

1. I would like to opt out of any electronic communication_☐_

2. I would like to opt out of e-mail only_☐_

3. I would like to opt out of text messaging only_☐_

4. I give my permission for DJLS Therapy Services to use e-mail or text messaging in regards to communicating to me about non sensitive and non-urgent issues to include matters regarding my appointments_☐_

Confidentially

The information you share with us is kept confidential and can only be released to someone else with your written consent. However, there are circumstances where we are legally required to provide information about you without your consent. This will occur if you or someone else is in danger of being harmed (matters of personal safety, safety of others, child abuse or elder abuse). If at all possible, we will discuss this with you in advance. More information about this is available in the HIPPA Notice of Privacy Practices.

HIPPA Notice of Privacy Practice

NOTICE OF PRIVACY PRACTICES (E*ffective March 26, 2013) Summary*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- •Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- •Obtain payment from designated third-party payers.
- •Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by DJLS Therapy Services LLC the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this

therapist/counselor has the right to change its Notice of Privacy Practices from time to time and that I may contact this therapist/counselor at any time at the address(s) listed to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this therapist/counselor restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the therapist/counselor is not required to agree to my requested restrictions, but if the therapist/counselor does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____

Client signature/Guardian Signature Date

_____ _____

Mental Health Therapist/Counselor's Signature Date