# Client Registration

**ALL information is required – If you have insurance you must complete ALL insurance questions.**

Client Name: _____ Age: _____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: _____

*Street* *Apt. #* *City,* *State* *Zip Code*

SSN#:_____-_____-_____Current living situation: ☐ alone *OR* ☐ with my _____

**Circle YES or NO next to each number listed, to indicate if it is OK to leave a message** May we send Appointment Texts? *YES NO*

Home (_____)____ - _____ *YES NO* Cell (_____)_____-_____ *YES NO* Email: _____ *YES NO*

Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Occupation: _____ Employer: _____ Employment Status: _____

Please list all persons you wish to involve in your treatment: _____

_____

**INSURANCE INFORMATION - REQUIRED**

Primary Insurance Co: REQUIRED _____

Name of Insured Person (parent/employee): _____ Insured's SSN: __ __ __ - __ __ - __ __ __ __

Member ID#: REQUIRED _____ Group #: _____

Relationship to Client: _____ Insured's Date of Birth: _____/_____/_____

Employer (Address, Phone #, Fax #, Email, Contact Person): _____

_____

**REFERRAL INFORMATION:**

Person/agency who referred you: _____ Reason for referral: ☐ Individual Counseling ☐ IOP ☐ Unknown

**EMERGENCY CONTACT**: **A consent is required for your Emergency Contact. Please fill out the appropriate consent form.**

Name: _____ Relationship: _____ Phone: (____) ____-_____

## AGREEMENT:

I certify that the information on this document is true & correct (Please sign and date below):

**Signature:** _____ **Date:** _____

**Client/Guarantor**

*All information is used strictly for the purposes of Imagine, LLC. Medical information provided is protected by federal HIPAA regulations.*

## MEDICAL INFORMATION

Primary Care Physician: _____(____)_____-_____
*Name Street Office # City, State Zip Code Phone*

Date of and Reason for Last Visit: _____

Psychiatrist: _____(_____)____-_____
*Name Street Office # City, State Zip Code Phone*

Date of and Reason for Last Visit: _____

Do you have any medical conditions (Including Hospitalizations): _____
_____
_____

List all current medications: (Name, Frequency, Dosage): _____
_____
_____
_____

Known allergies/medication reactions: _____
_____
_____
_____

In case of emergency what is your hospital preference:_____
_____
_____

## Medical History

| YES | NO | *If YES,* please explain: |
|---|---|---|
| ☐ | ☐ | Medical Emergencies (Seizures, Stop Breathing, Blackouts, Traumatic Brain Injury) |
| ☐ | ☐ | Active Infections (Aids, Hepatitis) |
| ☐ | ☐ | Pregnant or Suspected Pregnancy |
| ☐ | ☐ | Miscarriages, Abortions, Adoptions |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Weight Change (If YES, please list amount of weight loss/gain): |
| ☐ | ☐ | Liver |
| ☐ | ☐ | Blood Pressure |
| ☐ | ☐ | Short Term/Long Term Memory |
| ☐ | ☐ | Appetite Disturbance |
| ☐ | ☐ | Sleep Disturbance |
| ☐ | ☐ | STD's or Unprotected Sex |

**Have you ever had treatment for mental health or substance abuse in the past?** ☐ YES ☐ NO

*If YES*, please describe below:

| Specify: Counseling, Detox, Inpatient or Outpatient | Facility, Psychologist, Hospital, Therapist, or Physician | Dates | Prescribed Medication(s) | Why did you seek treatment? How long did it help? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Personal Information

Do you have any children? ☐ YES ☐ NO *If YES*, how many and what are their ages? _____

Do you have any custody issues? ☐ YES ☐ NO *If YES*, please explain: _____

Legal History: Have you ever been arrested? ☐ YES ☐ NO *If YES*, please list date of, reason for, and outcome of arrest:

_____

_____

_____

What interests/hobbies do you have? _____

What are your strengths and supports? _____

## Chief Concern

Briefly, why are you here? _____

_____

_____

_____

_____

_____

_____

**General Questionaire**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Do you feel tired all or most of the time? | ☐ | ☐ | Do you feel excessive guilt or a sense of worthlessness? |
| ☐ | ☐ | Do you have trouble sleeping? | ☐ | ☐ | Do you go days without sleep? |
| ☐ | ☐ | Do you find yourself avoiding social events and isolating? | ☐ | ☐ | Have you had any recent panic/anxiety attacks? |
| ☐ | ☐ | Do you feel sad most of the day, nearly every day? | ☐ | ☐ | Do you feel your thoughts are racing? |
| ☐ | ☐ | Are you currently experiencing anger outbursts? | ☐ | ☐ | Do you have a healthy appetite? |
| ☐ | ☐ | Do you worry excessively? | ☐ | ☐ | Do you use alcohol or drugs to get through tough times? |
| ☐ | ☐ | Are you currently experiencing thoughts of harming others? | ☐ | ☐ | Has drug or alcohol use been disruptive to your life or goals? |
| **YES** | **NO** | | **YES** | **NO** | |
| ☐ | ☐ | Are you currently experiencing any thoughts of suicide? | ☐ | ☐ | Have you sworn off alcohol or drugs repeatedly without success? |
| ☐ | ☐ | Have you ever attempted suicide in the past? | ☐ | ☐ | Are you being physically or sexually abused? |
| ☐ | ☐ | Do you “cut” or otherwise self-harm? | ☐ | ☐ | Do you feel supported by family or friends? |
| ☐ | ☐ | Do you get very upset when something reminds you of a specific past event? | ☐ | ☐ | Do you obsess about losing weight? |
| ☐ | ☐ | Do you re-experience a past traumatic event as though it were happening again? | ☐ | ☐ | Do you regularly purge after eating? |
| ☐ | ☐ | Do you currently experience visual or auditory hallucinations? | ☐ | ☐ | Is anyone requiring you to be here? |

# NOTICE OF PRIVACY AND CONFIDENTIALITY

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

## General Information:

The confidentiality of alcohol and drug abuse client records maintained by Imagine is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 132d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Generally, Imagine may not say to a person outside the program that you attend the program, nor disclose any information identifying you as an alcohol and/or drug user, or disclose any other protected information except as permitted by federal law. Imagine must obtain your written consent before it can disclose information about you for payment purposes. For example, Imagine must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Imagine can share information for treatment purposes or for health care operations. However, federal law permits Imagine to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate;
2. For research, audit or evaluation;
3. To report a crime committed on Imagine premises or against Imagine personnel;
4. To medical personnel in a medical emergency;
5. In connection with treatment, payment (insurance company) or health care operations;
6. To appropriate authorities to report suspected child or elder abuse and/or neglect;
7. As allowed by a court order.

Before Imagine can use or disclose any information about your health in a manner which is not described above, we must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

## Your Bill of Rights

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. Imagine is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency. You have the right to request that we communicate with you by alternative means or at an alternative location. Imagine will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Imagine, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances. Under HIPAA you also have the right, with some exceptions, to amend health care information in Imagine records, and to request and receive an accounting of disclosures of your health related information made by Imagine during the six years prior to your request. You also have the right to receive a paper copy of this notice.

**A.** In accordance with Title 6 of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title 9, Section 10800, and Americans with Disabilities Act of 1990, each person receiving services from an alcoholism or drug abuse recovery or treatment facility shall have rights which include, but are not limited to, the following:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2 and HIPAA and the right to receive this Privacy Notice.
2. To be accorded dignity in contact with staff, volunteers, board members and other persons. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours of admission, which can help in decision-making.
3. To be accorded safe, healthful and comfortable accommodations to meet his or her needs. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. To be free from verbal, emotional, physical abuse, inappropriate sexual behavior or contact, exploitation, humiliation, harassment and/or neglect.
5. To be informed by the program of the procedures to file a grievance (without fear of retaliation) or appeal discharge.
6. To be free from discrimination based on ethnic group identification, culture, sexual orientation, religion or spiritual beliefs, age, gender, skin color, socioeconomic status, language, or disability.
7. To be accorded access to his or her file and the right to own the information within his or her file with the exception of psychotherapy notes.
8. The right to request corrections of erroneous and/or incomplete information.
9. The right to prohibit re-disclosure of client information.
10. The right to request transmittal of communications in an alternative manner.
11. The right to obtain an accounting of disclosures.
12. The right to express preferences regarding counselor or service providers.

13. Fiduciary abuse of the participants is prohibited.
14. To be free from any marketing or advertising publicity without written authorization.
15. The right to provision of services will be responsive to the participants' social support and legal advocacy needs, when necessary.
16. The right to be free from intrusive procedures (strip searches or pat downs).
17. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law). You have the right not to receive unnecessary or excessive medication.
18. You have the right to accept or refuse treatment after receiving this explanation.
19. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
20. You have the right to be told about the program's rules and regulations before you are admitted. You also have the right to be told what is to be expected of treatment.
21. You have the right to be told before admission:
    a. the condition to be treated;
    b. the proposed treatment;
    c. the risks, benefits, and side effects of all proposed treatment and medication;
    d. the probable health and mental health consequences of refusing treatment;
    e. other treatments that are available and which ones, if any, might be appropriate for you; and
    f. the expected length of stay.
22. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan. You also have the right to meet with staff to review and update the plan on a regular basis.
23. You have the right to be told in advance of all estimated charges and any limitations on the length of services of which Imagine is aware.
24. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.

**B.** Each participant shall review, sign and be provided at admission, a copy of the participant rights specified in A1 through A24 above. The program shall place the original signed bill of rights document in the participant's file.
**C.** The provider shall post a copy of the participant rights in a location visible to all participants and the general public.
**D.** The follow-up after discharge cannot occur without a written consent from the participant.
**E.** Any program conducting research using participants as subjects shall comply with all federal regulations for protection of human subjects (Title 45. Code of Federal Regulations 46.) However, you have the right to refuse to take part in research without affecting your regular care.

**Imagine Duties**
Imagine is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Imagine is required by law to abide by the terms of this notice. Imagine reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Revised notices will be posted in all Imagine offices and website, as well as given to all active patients.

**Complaints and Reporting Violations**
You may complain to the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201, to MS State Board for Examiners for Licensed Professional Counselors PO Box 1497, Yazoo City, MS 39194 and to the MS Department of Mental Health at 1101 Robert E. Lee Building, 239 N Lamar St., Jackson, MS 39201 if you believe that your privacy rights have been violated under HIPAA. Imagine will take no retaliatory action against you if you file a complaint about our privacy practices.

**Contact:**
If you have questions about this notice or any complaints, please contact our President at 601-982-5376.
Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United State Attorney in the district where the violation occurs.

**Effective Date:** This notice comes into effect on July 1, 2008.

**Acknowledgement:** I hereby acknowledge that I received a copy of this notice.

## Client Signature: _____ Date: _____

**Imagine was unable to obtain this acknowledgement of receipt due to:**
□ Client refused to sign acknowledgement □ Client was unable to sign acknowledgement □ Client left the facility before the end of the assessment and is not entering treatment □ Other:_____

Imagine Staff Signature: _____Date: _____

# Consent for Treatment Agreement

Thank you for choosing Imagine as your treatment provider. The following information is provided to you to help clarify any questions you might have before, during, or after treatment.

**Please print your initials on the lines provided.**

## _____Therapeutic Services *(Please Initial)*

Psychotherapy is not easily described in general statements. It varies depending upon the personality and relationship of the therapist and client. Although successful outcomes are more likely, outcomes are not always predictable due to several factors. Among these factors are clients' reluctance to be totally truthful with the therapists, difficulty in carrying through on therapeutic goals outside the sessions, continued use of mood-altering drugs, and inconsistent commitment to change. It calls for active participation by you, the client.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy can have lasting benefits for those who go through it. It can lead to better relationships, happier families, improved mood, solutions to specific problems, and significant reductions in stressors. Most people experience a better quality of life.

Our first visit will involve a thorough assessment to determine the appropriate level of care. In some cases, particularly with addictions clients, we may recommend medical detox, inpatient alcohol and drug treatment, or enrollment in Imagine Behavioral Health's Intensive Outpatient Program. Some clients may only need a weekly individual session. The assessment assists in creating a personal Treatment Plan that guides us through the journey toward your successful therapy. Therapy involves a large commitment of time, energy, and money; so you should feel fully informed and in full agreement with all therapeutic decisions. Whenever doubts, questions, or other issues arise it will be your responsibility to seek answers or assurance.

Imagine employs and utilizes a multidisciplinary team of professionals which includes master's level therapists, md's and interns.

## _____Therapeutic Relationship *(Please Initial)*

Your relationship with your therapist is professional and therapeutic. In order to guarantee this, it is imperative that we not have any other type of relationship with you. Our code of ethics prohibits us from socializing with you, receiving special favors from you or your business, or otherwise establishing or attempting to establish any relationship outside the narrow boundaries of our therapist-client relationship.

## _____Fees, Appointments *(Please Initial)*

Assessments/initial visits are $195. After your assessment, your therapist will make a recommendation regarding the type and frequency of your sessions based on your individual treatment needs. The cost of individual sessions will vary based on your insurance coverage and the length of your sessions. *If you are a cash pay patient, the cost is $125 for a 45 minute session and $200 for a 90 minute session.* Other services may have different fees. Depending on your insurance coverage, you may be required to pay your co-pay, provided you have met your annual deductible and your provider recognizes LPCs. We will file your insurance for you and do our best to collect from them. If they fail to pay, you will be responsible for the costs. Special payment arrangements are possible with long-term clients. If you have to cancel, you must notify the office at least 24 hours in advance. Failure to do so will result in a charge of $75 to your account, which insurance will not cover.

## _____Document/Letter Preparation Fees *(Please Initial)*

We also have a charge for document/letter preparation. This includes disability paperwork, work related documents and letters for legal matters. The fee is $25 per 15 minutes and is billed in 15 minute increments.

## _____Confidentiality *(Please Initial)*

Without written consent, all discussions between your therapist and you are strictly confidential. Possible exceptions to confidentiality include the following situations:

1. Pursuant to an agreement with a qualified service organization/ business associate;
2. For research, audit or evaluation;
3. To report a crime committed on Imagine premises or against Imagine personnel;
4. To medical personnel in a medical emergency;
5. In connection with treatment, payment (insurance company) or health care operations;
6. To appropriate authorities to report suspected child or elder abuse and/or neglect;
7. As allowed by a court order.

If you have questions concerning confidentiality, please bring them to my attention so that we can discuss them. In the event that you enroll in Imagine IOP, your records will be shared with the treatment team and your psychiatrist. The treatment team is made up of all the counselors that you see during your group sessions.

I have read and understand the above and I agree to receive counseling services from Imagine Behavioral Health and/or its therapists.

### Client (or Guardian):

**Signature** **Date**

### Imagine Treatment Provider(s):

Provider Signature *(Please Select Name Below)* Date

☐ Baxter Hogue, LPC – Clinical Director
☐ Kaleigh Countiss, LPC – Adult Substance Program Director
☐ Nic Tew, LCSW – Adolescent & Young Adult Program Director
☐ Byron Galloway, LMFT – Staff Therapist
☐ Chris Wimberley, LMFT – Staff Therapist
☐ Jane Fuller, LPC – Staff Therapist
☐ Other: _____

# No Show / Cancellation Policy

## Notice:

Effective April 1, 2016

**Policy:**

Failure to notify the office 24 hours in advance of your scheduled appointment that you are unable to attend will result in a charge in the amount of $50.00. ***Following the first no show appointment you will be required to put a credit card on file with the front office to cover future no show appointments.***

Please note: **THIS CHARGE IS NOT COVERED BY YOUR INSURANCE.**

Exceptions will be made in emergency circumstances; however, this will be at the discretion of the business office.

Your signature below is your acknowledgement of the above mentioned policy.

_____ _____

Client Signature Date

_____

Witness